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Generic and professional culture care meanings and practices of Finnish women in birth within Leininger's theory of culture care diversity and universality

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GENERIC AND PROFESSIONAL CULTURE CARE MEANINGS AND PRACTICES OF FINNISH WOMEN IN BIRTH WITHIN LEININGER'S THEORY OF CULTURE CARE DIVERSITY AND UNIVERSALITY

by

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DEDICATION

The author wishes to dedicate this dissertation to my Finnish son Lars Joachim Salokorpi and the family Salokorpi and to my daughter Saara Louisa Torma and the family Torma who provided the impetus to study their country of Finland. It is through their love that my eyes to the world have been opened and through the graciousness of their hospitality that this research was made possible. They all will truly be a part of my family forever.

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CHAPTER I

Introduction

During the past three decades, transcultural nursing has become an essential, formalized area of study and practice in nursing worldwide. The discipline is contributing many new insights to nurses who provide congruent and beneficial care practices. Since the mid 1950's, Dr. Madeleine Leininger, founder and leader of transcultural nursing, has led this revolution in nursing with its focus on care from a transcultural perspective. Her efforts have stimulated a major cultural care movement that has influenced nursing education, practice, and research to provide sensitive, holistic, competent, and safe nursing care to diverse cultural groups. Moreover, with increased immigrations and demands of cultures to have health care fit their cultural needs, current emphasis on health care reform that will give specialized attention to the well being of people worldwide has become essential to all nurses and health care providers.

Most importantly, from a transcultural perspective and as Leininger (1997) states, health care is culturally constituted or culturally based in the values and beliefs of people. Women's reproductive and infant's health care is greatly influenced by various dimensions of a culture such as education, economics, politics, values and lifeways, kinship, religion and philosophy, technology, language, history, etc. and needs to be addressed. Kay (1982) states, "Women's health care in every society is a reflection of the total culture." Throughout the world, the health of women is a prime indicator of a culture.

Neff-Smith, Lacatell, & Moore (1996) claim that women's health is primarily determined by social and economic status. Raising the status of women through literacy, legal protection, economic opportunity, reproductive choice, and the valuing of women's work, they believe, will improve the health of women transculturally. Nevertheless, raising their social and economic status is best accomplished if their cultural values, beliefs, and lifeways are an integral and imperative part of understanding and helping women to improve their health.

Many individuals believe that health care in the United States is largely based on the medical model approach which is focused on treating the human body like a machine that can be simply protected or repaired from disease with chemical or physical intervention. Moreover, the medical model tends to fragment human care and the client is not always evaluated from a holistic, caring perspective. This segmented approach, deeply rooted from the 17th century scientific paradigm with a deterministic view of biology, fails to identify the influence of culture and the other primary determinants of human health - "environment and personal behavior" - as described by McKeown (1994, p. 6).

Even the definition of health is described as a negative concept: "the absence of disease or injury" which lends itself toward a reactive, "sickness care system" (Evans & Stoddart, 1994, p. 15). This perspective was specifically rejected by the World Health Organization (WHO) when it defined health as "a complete physical, mental, and social well-being, and not merely the absence of disease or injury" (p. 15). Unfortunately, culture is still not an

explicit concept within this definition. Health is indeed more than a collection of negative features. Cultural values, beliefs, and lifeways need to be incorporated into this definition in order to consider health as a concept from a worldwide perspective.

In his discussion of world health care, Richard Lamm (1994) claims that even though the American Medical Association contends that the United States has "the best health care system in the world" (p. 152), it does not keep its people as healthy as other industrial competitors. The United States spends more per capita that any other country in the world on health care. Since 1965, this country's health care costs have increased from approximately 5% of the gross national product to 15% currently, with anticipated projections of 20% if changes are not made (Olds, 1996). Lamm asks the question, "We clearly have the most expensive, but is it the best?" (Lee & Estes, p. 152).

> Despite our technological superiority,
>
> an American male is 15th in the world in life expectancy and American females are eighth; we are 20th in infant mortality; 12 nations have lower rates of cancer and 25 nations have better cardiovascular health. For all our spending, we do not keep our people as healthy as the Japanese, the Canadians, or the Europeans (p. 152).

He also contends that the number of hospitals and physicians do not translate directly into better health. "Human health has improved and life expectancy increased mainly because of improved standards of living, particularly improved nutrition, decisions about family size and birth control, and public health measures: sanitation, refrigeration, chlorination, and vaccination" (p. 153).

Anderson (1997) reports, using data from the Organization for Economic Cooperation and Development (OECD), in 1996 the United States spent 14.2 percent of its gross domestic product on health care, spending the most per capita with $3,708 spent per person on health care services. He also claims that compared to France, Germany, Japan, Great Britain, Canada, and Italy, only the United States has not achieved a universal publicly mandated health insurance program with less than half of its population eligible in 1995. And finally, between 1990 and 1995, the infant mortality rate in the United States declined to 8.0 per 1,000 live births but this still left the United States at 23 out of 29 industrialized countries because other countries had shown more rapid improvement in reducing infant mortality.

While these statistics are important, certain dimensions within a particular culture that go beyond the health care system itself become important in influencing the health of people, especially the health of women. The cultural values, beliefs, and lifeways of women are critical in establishing and maintaining effective health care programs and services for them. Furthermore, it is the cultural dimensions such as education, economics, politics, kinship, religion and philosophy, technology, language, and history that provide a means and key approach to holistic health as supported by Leininger (1978, 1995) and other transcultural nurses. Examination of all cultural dimensions, including their diversities and universalities, should contribute to a more holistic approach to improving the health and well being of women worldwide.

The Fifth International Congress on Women's Health Issues held in

Copenhagen, Denmark in 1992 recognized the interactive relationship between health and various cultural dimensions of the environment (McElmurry, Norr, & Parker, 1993). Over 350 participants from 31 countries agreed that health is determined by the interaction of such cultural dimensions as economic, political, and social forces but failed to recognize the totality of the culture to also include such dimensions as education, kinship, religion and philosophy, technology, language, and history. The recommendations that were endorsed by this congress are as follows:

> 1. Health work should be based on the recognition that human health cannot be protected and improved without protecting the eco-systems that sustain all life.
> 2. Social, political, and economic justice at global and national levels needs to be fundamental to health policy.
> 3. Democratization and decentralization of knowledge, resources, and decision-making are essential for attaining health for all.
> 4. Education for empowerment and occupational opportunities is fundamental for improving health.
> 5. Unnecessary and harmful medicalization of health practices needs to be exposed and stopped.
> 6. Humans beings all over the world should work against dumping of harmful and useless drugs, tobacco products, reproductive technologies, and industrial and toxic waste by the industrialized countries in the less technologically developed countries (p. 303).

These recommendations help to support the need to examine some of the cultural dimensions of women's health in order to provide care that is relevant, responsible, and meaningful to women worldwide.

Transcultural nursing, however, is the scientific and humanistic discipline and profession that focuses on culture, care, and health to establish holistic and meaningful health care (Leininger, 1978, 1991a, 1992, 1995, 1997). The

discipline is focused on cultural care dimensions and health in relation to human conditions, lifestyle patterns, wellness modes, health prevention, and health maintenance that is the framework which all nurses can use to provide safe, sensitive, and holistic care to women.

Within this framework, diverse and universal generic and professional care meanings and practices for women need to be examined in terms of their reproductive health. Reproductive health and more specifically, birth, is a universal biological process strongly influenced by cultural and social dimensions of history, language, environment, kinship, values, etc. Finn (1993), a transcultural nurse, examined the meanings of generic and professional care and non-care as experienced by ten European-American women in birth. She explored the significance of worldview, cultural, and social structure factors as the basis of care. She found that childbirth beliefs and practices tend to vary with respect to the patterns of care during pregnancy, birth, and postpartum. The finding was important for birthing women and emphasized that women their attendants should have similar, compatible beliefs associated with the birth process.

Health professionals caring for women in birth in any culture need to be knowledgeable about culture and alert to cultural differences and similarities. They need to be sensitive and attend to the care meanings and practices as they strive to meet women's recurrent and diverse needs. A fundamental approach toward this goal is to broaden their view of birth from the typically ethnocentric ways to consider other care meanings and practices within other

cultures (Newton, 1982).

In the early 1960's, Leininger, founder of the field of transcultural nursing, and later other transcultural nurses, saw the urgent need to study different cultures worldwide in order to understand cultural differences and similarities. One major aspect of transcultural nursing was to study generic (folk) and professional care meanings and practices related to culture care in order to provide holistic and meaningful care. Transcultural knowledge is critical to discover care meanings and practices which provide the basis for care that is humanistic, beneficial, and fits the lifeways of diverse cultures. The focus on discovery of transcultural nursing knowledge is gradually transforming nursing and health care worldwide (Leininger, 1995, 1997).

To further advance health care for women, transcultural nursing knowledge, with the study of care meanings and practices related to culture, is crucial to providing culturally congruent care. By critically assessing one's own care meanings and practices, nurses can learn to care for women in birth in meaningful ways. Health care professionals need to use knowledge from transcultural nursing research and develop skills to foster change that will lead to culturally congruent care for women. Transcultural nursing's conceptual, theoretical, and research focus has become essential in all aspects of health care for women today.

In the field of anthropology, Brigitte Jordan (1993) also advocated the study of birth practices from a transcultural perspective. She claims that because birth is a universal event, a wide range of variability in care beliefs and

practices should be studied. She explains that in most cultures, birth is "strictly women's business" (p. 5); therefore, the organization of female networks, interests, and strategies for change could be improved and expanded. Jordan also challenges the standard medical model approach to birthing practices in the United States. She states, "Some of the very obstetric practices that are currently exported to developing countries by the medically oriented, technologically sophisticated nations have ironically taken on a controversial status at home" (p. 5). This sense of superiority of Western medicine with all of its technological advances challenges one's moral thinking with regard to "helping" other cultures achieve "a better way".

For many women, birth in the United States is an experience of professional management with medical technology that they perceive to be necessary to ensure a safe, healthy outcome. The ethos of birth has evolved from an experience of trusting women's instinctual knowledge and inner or folk wisdom within the home setting to an experience of dependency on the highly medicalized professional with the necessary technology and machines to manage the birth for her within the hospital setting. Anthropologist Michaelson (1988), contends that most women prefer to trust a medicated, hospitalized birth in her discussion of choices in childbirth and negotiating for a more satisfying birth experience. Poland (1988), a nurse anthropologist, interviewed inner-city women in her research on prenatal and birth care seeking behavior and reported that some women sought a university-affiliated hospital birthing setting because they "valued the technical expertise of the physicians ... and

anticipated benefiting from the new technology" (p. 60).

Despite the technologically advanced medical system, the United States has needed to continually upgrade perinatal care outcomes in contrast with other countries. For example, infant mortality in the United States ranks 22nd among industrialized nations (Rice, 1994). In 1986, Japan had the lowest infant mortality rate (5.2 deaths per 1,000 live birth) in the world and the second lowest perinatal mortality rate (7.3 deaths per 1,000 live births). Finland's perinatal rate was lowest in the world at 6.4 deaths per 1,000 live births (Rice, 1994). "The infant mortality rate for the United States in 1986 was twice the rate for Japan, and the perinatal mortality rate was almost two thirds higher than that for Finland" (p. 46). Finland gives high priority to the health of its children and the perinatal mortality statistics reflect this effort. Rajanen (1981) states, "To be born in Finland is to have the best chances to survive" (p. 95).

Domain of Inquiry

The domain of inquiry for this study focuses on the generic and professional culture care meanings and practices of Finnish women within Leininger's theory of Culture Care Diversity and Universality. A domain of inquiry refers to a "particular area of study to be investigated and which has a boundary such as caring phenomenon" (Leininger, 1985, p. 241). "It must have a potential or actual nursing perspective generally about caring phenomena of a culture or subculture" (Leininger, 1997b, p. 47). In order to provide culturally congruent care, an understanding of the diverse and holistic influences of the cultural and

social structure dimensions are important. However, to examine generic (folk, lay, naturalistic) and professional care, the worldview, environmental context, language, and ethnohistory needed to be studied. These influences, along with the meanings and practices of generic and professional care, are critical to identify and understand culture care.

Generic and professional care are an integral part of the theory of Culture Care. Accordingly, Leininger (1991a) has defined generic care (caring) as follows:

> Those culturally learned and transmitted lay, indigenous (traditional) or folk (home care) knowledge and skills used to provide assistive, supportive, enabling, facilitative acts (or phenomena) toward or for another individual, group, or institution with evident or anticipated needs to ameliorate or improve a human health condition (or well being), disability, lifeway, or to face death (p. 38).

Professional nursing care (caring) has been defined by Leininger (1991a) as follows:

> The formal and cognitively learned professional care knowledge and practice skills obtained through educational institutions that are used to provide assistive, supportive, enabling, or facilitative acts (or phenomena) to or for another individual or group in order to improve a human health condition (or well being), disability, lifeway, or to work with dying clients (p. 38).

A domain of inquiry is important to gain indepth knowledge about a culture. Thus, it was very important to study Finnish women in birth and explore how their beliefs, values, and needs regarding generic and professional care were expressed. As an educator and clinician with years of experience in providing care to women in birth, the researcher learned in transcultural nursing about the various care meanings and practices provided by generic and professional

caregivers.

In the United States, women often relegate their control and decision making capabilities regarding their birth experiences to the professional who may often have little knowledge of cultural care needs. Exploring transculturally the diversities and universalities which exist in the generic and professional care of women in birth is essential to provide culturally congruent care that is sensitive to women's needs during birth. This theory held by Leininger (1991a, 1995) fits with the domain of inquiry to discover and explain the health and well being of women. How these care meanings and practices for women in the United States differ from other cultures is an important area of interest in relation to Finnish women in birth. With the development of transcultural nursing as a formal area of study and practice, it is encouraging to have comparative studies of women in birth become a reality. To study the generic and professional care meanings and practices of Finnish women in birth as a domain of inquiry contributes essential knowledge for the discipline of transcultural nursing.

Purpose of the Study

The purpose of this transcultural nursing study was undertaken to discover the generic and professional care meanings and practices of Finnish women in birth using Leininger's theory of Culture Care Diversity and Universality. Most importantly, the study was focused on the generic and professional care of Finnish women in birth within their own cultural and environmental context. In-depth studies of generic and professional care meanings and practices of

women in birth of diverse cultures within their naturalistic cultural context offers an opportunity to discover realities and meanings of birth in one's own culture. This study was needed to advance nursing knowledge by discovering the lifeways of women and the humanistic caring they need. Discovering cultural differences and similarities in the birthing experiences of women worldwide will help to understand why differences and/or similarities exist in relation to perinatal morbidity and mortality.

In many cultures, there are some kinds of generic (folk), indigenous, naturalistic health care systems and sometimes professional health care systems. Research-based knowledge on generic and professional care was predicted in Leininger's theory to be beneficial, humanistic care that is healthy and congruent with a woman's culture care values and needs during this important life event.

It was the researcher's position that generic and professional care did not provide care that was congruent or fit with a woman's cultural care values and needs. Understanding a woman's worldview, cultural and social structure influences, and the generic care meanings and practices needed to be discovered in nursing and especially transcultural nursing. Furthermore, a woman's culture care values and needs are influenced by professional health care providers whose own culture values and needs are held to be deeply embedded in medical model values and beliefs which may be in cultural conflict with the generic (naturalistic, lay, and folk) beliefs. Women in birth have their own beliefs and values about generic care meanings and practices

when seeking professional care and these need to be discovered. Likewise, professional nurses have beliefs and learned principles and practices about birth not only from nursing but also from a medically defined, professional view.

This researcher had a longstanding interest to study diverse cultures and especially of women in birth. A mini-ethnonursing study of generic and professional culture care meanings and practices of European-American women in birth was conducted in an urban setting within the United States in order to gain experience with the ethnonursing and audiovisual methods and indepth knowledge of Culture Care theory. This preliminary study demonstrated differences between generic and professional care and indicated the existent need to pursue further a maxi-ethnonursing study in Finland. With this field experience and awareness of transcultural nursing knowledge, the researcher saw the relevance to obtain the rich data about women of diverse cultures with their birthing places, symbols, rituals, expressions, and patterns. The researcher holds, therefore, that generic and professional care of women in birth tend to be in conflict with each other and these care meanings and practices are important to discover culturally congruent care.

The goal of this specific study was to discover the transcultural care meanings and practices of Finnish women in birth in order to identify ways to provide meaningful and responsible culturally congruent care. The researcher was interested to learn about the Finnish culture of women in birth and reflect upon current practices in the United States in order to improve perinatal morbidity and mortality. The Culture Care theory and ethnonursing method

seemed most appropriate to meet this goal. Discovering transcultural theory, the substantive knowledge of another culture with a low perinatal mortality rate could probably help the infant mortality rate in the United States. In 1995, the United States ranked 22nd among the industrialized nations, the perinatal mortality rate being almost two-thirds higher that that for Finland (Rice, 1994). Between 1990 and 1995, the infant mortality rate in the United States declined to 8.0 per 1,000 live births; whereas, in Finland, in 1993 the infant mortality rate was 4.4 per 1,000 live births, their lowest ever (Ministry of Social Affairs and Health, 1995).

The purpose of this study, therefore, was to document, describe, and systematically analyze the cultural care meanings and practices of Finnish women in birth. Using Leininger's theory of Culture Care, the multiple influences of the social structure and cultural dimensions related to generic and professional care were systematically studied and analyzed.

Rationale and Significance for Nursing

In a holistic and naturalistic sense, pregnancy and birth in the United States should be considered more than a biological human condition, a physiological process, often times treated as a pathological event. The experience of women in birth in the United States tends to reflect Western Medicine's view of birth as an unnatural process, a biological event that could only produce a positive outcome if successfully managed by professional others. From a transcultural perspective, pregnancy and birth is a cultural and often spiritual experience for women, an event that is rich with cultural meanings and practices. Davis-Floyd

(1988) states, birth in Western society is "an experience belonging uniquely to women, yet all too often removed from their control" (p. 9). Some women in the United States are viewed as products of the American medical system with the definition of birth lying within the medical domain. Some women have been taught to "delegate responsibility for their physiological - and especially their sexual and reproductive - functions to doctors, drugs, and medical technologies" (p. 12). Davis-Floyd further states that

> in their well-planned efforts to create an individually satisfying rite of passage, many of these women won battles with doctors on technical and scientific grounds, only to lose in the end to hospital ritual cloaked in scientific guise (p. 12).

These claims attest to the need to reestablish the experience of women in birth as a holistic and naturalistic experience, one that incorporates care as the essence of nursing. As transcultural nursing specialist Miller (1997) has asserted,

> If care is the essence of nursing, then it is critical to discover the holistic context of this phenomena. It is the intimate, trusting relationship between the researcher and the informant in the naturalistic paradigm that enables us to learn the truth about its significance to nursing and health (personal communication).

Women need to reclaim birth as a humanistic experience, one that is culturally defined and congruent in meaning, an experience that focuses on care, generic and professional.

In a special classic report on obstetrics in the United States prepared for the International Childbirth Education Association entitled "The Cultural Warping of Childbirth", Doris Haire (1972) most eloquently states,

Obviously there will always be medical indication which dictate the use of

> various obstetrical procedures, but to apply these American practices and procedures routinely to the vast majority of mothers who are capable of giving birth without complication is to create added stress which is not in the best interests of either the mother or her newborn infant" (p. 8).

As a result of the medicalization of birth in the United States, an increased dependency of women on professional medical management has evolved in Western Society. Once considered a normal, biological event that women valued within the cultural context of family and friends, their importance has largely disappeared. It appears that Western women have often surrendered or relinquished their folk or generic knowledge and caring practices to the medical and nursing professional using a medical focus within an organized, routinized, formalized setting. Far too limited study has been given to the naturalistic caring practices of women in birth that encompass the generic (folk) caring practices and intergenerational aspects. Jordan (1993) speaks of the "ethno-obstetric system that consists of an empirically grounded and often supernaturally sanctioned repertoire of practices". She contends that these systems have in place a set of established practitioners who subscribe to a body of beliefs about the nature of the birth experience which they share with childbearing women of their community.

Throughout time women have shared information about and assisted each other in childbirth. Historically, women were not taught to read and write, and so women learned from other women through the spoken word. These words evolved as myths and wives' tales which later came to be discarded by educated professionals as worthless, trivial information, and certainly

counterproductive to the development of medicine (Achterberg, 1990).

Until the late nineteenth century, childbirth was a family event in which women gave birth at home, often with the help of a midwife. The Industrial Revolution, with attendant urban crowding and associated health problems, led to higher and higher rates of maternal and infant death from puerperal fever, sepsis, and/or infant diarrhea (Wertz, 1979).

In the past, economic and ideological reasons for professionals to manage and control birth prevailed. In order for Western medical students to conveniently learn about childbirth and its mechanistic processes requiring intervention, childbirth was moved from the naturalistic home setting to the hospital setting. The associated changes for professional domination of obstetrics, drugs, medication for pain, and infection control in birth, as well as weakening of family bonds brought on by industrialization moved birth from "strictly women's work" to the hospital. But Western women did not always see this transition from home to hospital as a loss of an important part of their birth experience. Western women considered the alienation from family and friends and their folk caring practices as a compromise for relief from pain and a greater guarantee of life and health (Michaelson, 1988).

During the early twentieth century women accepted centralized and routinized birth practices over which they had no control in the belief that birth would be safer. Medical education reform resulted in well trained physicians with far more scientific knowledge that the average person and with powerful medications that were only obtainable through a physician's order. The age of

physician reliance began with increasing medical specialization and evolving technology. Not until midway through the twentieth century, fueled by consumer's rights, the women's movement, and the increased use of midwives, did women begin to question the rigid policies, medicalization, and routinization of birth care and practices.

Today, there are few culturally based maternal-child and/or birth studies completed that would enable nurses to provide more culturally congruent care. Even fewer studies are completed by nurses who are prepared in transcultural nursing. Such knowledge related to the domain is urgently needed to enable nurses to provide culturally congruent care that would contribute to the health and well being of women worldwide.

Transcultural nursing is "a formal area of study and practice in nursing focused upon comparative holistic cultural care, health, and illness patterns of individuals and groups with respect to differences and similarities in cultural values, beliefs, and practices with the goal to provide culturally congruent, sensitive, and competent nursing care to people of diverse cultures" (Leininger, 1995, p. 4). It is considered that people of diverse cultures have a human right to have their cultural values, beliefs, and needs met by nurses as professional care providers; therefore, transcultural nursing is a legitimate area of study and practice requiring nurses to learn about people of different cultures and develop competent practices to meet the their needs.

Also transcultural nursing requires that nurses be educated in order to know, understand, and practice transcultural nursing. In-depth knowledge

about cultures and care can only serve to enhance nursing's understanding of cultural lifeways, values, and beliefs that have maintained health, prevented illness, or led to greater sense of well being for the people. Comparative differences and similarities among cultures are the focus of transcultural nursing in terms of humanistic care, health, wellness, and illness patterns, beliefs, and values. Discovering why these differences or similarities exist allows nursing to analyze critically the traditional medical or nursing approach to care in light of new perspectives seen across cultures.

Culture is defined by Leininger (1995, p. 9) as "the learned and shared beliefs, values, and lifeways of a designated or particular group which are generally transmitted intergenerationally and influence one's thinking and action modes". Culture is essential to know, understand, and serve people of the world. Culture is central to transcultural nursing in that nurses must understand nursing care lifeways, actions, and decision modes and how people are influenced by their way of being in the world.

Transcultural nursing's focus on human care and caring expressions, values, patterns, symbols, and practices within diverse cultures was first recognized for its importance by Leininger in the mid 1950's and gradually the systematic study of transcultural care with a focus on care as the central and dominant domain to nursing has been pursued by transcultural nursing scholars. To facilitate this movement and understand the why of cultural differences or similarities, the theory of Culture Care Diversity and Universality was established by Leininger. This lead to the discovery of transcultural care

knowledge with many new and important insights for nurses (Leininger, 1981, 1989, 1991a, 1995). Transcultural nursing as a formal and essential area of study and practice became the new and important paradigm for the profession, one in which will help nurses to function effectively in our multicultural world.

With the development of transcultural nursing came the need for qualitative studies in order to get indepth emic knowledge and the meaning of culture care. There was an urgent need to discover the covert, subtle, subjective, and objective emic evidence about the cultural care meanings and practices to substantiate quality based and congruent care to people of diverse cultures (Leininger, 1985, 1991a, 1995).

Transcultural nursing was essentially a new approach with a different nursing paradigm which necessitated changes in the thinking, education, and practice of nurse researchers to enter the culture care world of informants. The basic beliefs of nurse researchers, who saw the importance of the naturalistic and humanistic approach for human caring and transcultural nursing, were upheld by Leininger (1985) who provided research axioms and principles for naturalistic inquiry. The naturalistic or qualitative nurse researcher believed that

> realities are multiple, constructed, and holistic, that knower and known are interactive and inseparable, that only time- and context-bound working hypotheses are possible, that all entities are in a state of mutual, simultaneous shaping so that it is impossible to distinguish causes from effects, and that inquiry is value bound (Lincoln & Guba, 1985, p. 37).

Leininger held that to discover caring and transcultural nursing phenomena for a humanistic and scientific knowledge required a qualitative approach in which

naturalistic, open and broad discovery of holistic life forces were important (Leininger, 1985). This was important for detailed cultural knowledge of the people, rather than researchers' opinions, theories, or views. Congruent with this new paradigm was the researcher's desire to discover holistic, humanistic caring practices of women of diverse cultures related to transcultural nursing's knowledge.

To discover the meanings and practices of generic and professional care of Finnish women in birth that will ultimately contribute to their health and well being, Leininger's theory of Culture Care was used. The theory and the ethnonursing method were designed to explain the purpose of the study. The audio-visual method was used to show detailed caring expressions and patterns of care during birth. The researcher focused mainly on emic knowledge, but also etic (outsider knowledge) and was alert to outsider, non-informant knowledge to discover any differences or similarities related to culturally congruent care so that Finnish women could benefit from care. The etic, or outsider's views were considered with the emic, or generic folk knowledge, in order to obtain an any contrasts or comparisons of generic and professional care and guide transcultural nursing practices. Both similarities and differences in generic and professional care were of interest to discover holistic transcultural nursing knowledge related to culturally congruent care.

Research Questions

The research questions within the domain of inquiry which served as a guide and provided direction for the conduct of this study were:

1. In what ways did the cultural and social structure dimensions influence the generic and professional care meanings and practices of Finnish women in birth?

2. What were the generic and professional care meanings and practices of Finnish women in birth?

3. What cultural diversities and universalities existed in the care meanings and practices of Finnish women in birth?

4. What nursing modalities of Leininger's Culture Care theory were indicated to provide culturally congruent care of Finnish women in birth?

Theoretical Framework

Leininger's theory of Culture Care Diversity and Universality (Leininger, 1985, 1988, 1991) was used to discover the human care diversities and universalities in relation to worldview, social structure, and other dimensions, for Finnish women in birth. Since the goal of the theory was to discover culturally congruent care knowledge, the researcher's goal, used with the theory, was to identify the generic and professional cultural care meanings and practices that would contribute to health and well being of Finnish women.

Leininger's Culture Care theory focused on worldview, cultural and social structure dimensions, ethnohistory, and related factors to obtain a holistic view of the domain of inquiry which was focused on culturally based care meanings and practices of Finnish women in birth. Care, as the essence of nursing, is an important ontological and epistemic focus for nurse scholars to know and understand nursing science (Leininger, 1988b, 1988c, 1991). Leininger stated

in 1960 that care should be the central phenomenon of nursing but explicated transculturally. It is an expression of respect for and response to wholeness, an active engagement in the person-to-person process of being and becoming (Boykin & Schoenhofer, 1989).

Roach (1987) stated that "caring is the human mode or manifestation of being" (p. 45) and as such "entails the capacity or power to care, a capacity linked with and inseparable from our nature as human beings" (p. 47). Watson described caring as the "moral ideal of nursing" (1985, p. 29), a moral commitment toward protection, enhancement, and preservation of human dignity. Watson's theory of human care addresses values associated with respect for the mystery of being-in-the-world and acknowledges the three spheres of being as mind-body-soul, the spiritual or inner aspects of self (Boykin & Schoenhofer, 1989). Noddings states that the very concept of ethics as arising from the consciousness of self as caring, that commitment to act on behalf of the cared for, and a continual interest in the reality of the cared for are essential ethical elements in caring situations (1984).

Leininger (1991a) viewed transcultural nursing as a scientific, human care discipline and profession, and that caring was a universal feature of nursing in all cultures. Leininger postulated that human care was an essential human need (1980). Human care was believed to vary transculturally in meanings, expressions, patterns, symbols, and in other ways. Human care was held to be a universal nursing phenomena, but that variabilities or diversities existed in meanings, patterns, or expressions of care. Discovering the diversities and the

universalities about human care in cultures worldwide is a major and essential challenge to nurses worldwide if nursing were to serve people in culturally congruent ways.

Leininger, with interest in transcultural nursing and human caring, developed the first theory in nursing on Culture Care Diversity and Universality (1976, 1981, 1984, 1988b, 1988c). She held that human care was an essential human need and predicted that care is the "essence of nursing and a central, dominant, and unifying domain of nursing knowledge and practice" (1991a, p. 31). While the roots of culture came from anthropology and care largely from nursing, a new theoretical formulation and nursing perspective was developed by Leininger to discover knowledge that would serve the discipline of nursing. Culture and care were synthesized as a construct entity, tightly embedded into each other in order to explain, interpret, and predict phenomena relevant to nursing. Culture care was conceptualized and reformulated into a nursing perspective in order to study systematically and rigorously, and to scientifically develop a new or distinct body of nursing knowledge and to establish transcultural nursing as a discipline and profession (Leininger, 1991a).

From the beginning, the theory of Culture Care Diversity and Universality was conceptualized from a global or worldwide perspective to advance the discipline of nursing knowledge. It was viewed as imperative for discovering epistemic and ontological knowledge for the nursing discipline. In order to achieve this goal, worldview, cultural and social structure factors, ethnohistory, context, and language had to be studied and incorporated into transcultural

nursing. This global aspect of transcultural nursing knowledge is essential to guide nurses functioning in a multicultural world. The goal was to arrive at ways to provide culturally congruent care that supports the health and well being of individuals. It was a very new and much broader perspective in nursing and generic and professional care. The theory provides an essential direction for nursing of the future in order to be socially relevant and a substantive base for nursing knowledge to guide practice (Leininger, 1991a).

Within the theory, the phenomena of generic and professional cultural care meanings and practices was held as important. Accordingly the researcher was interested to discover generic and professional care of Finnish women in birth. Leininger's theory of Culture Care was used with the Sunrise Model to depict the major dimensions of the theory, namely worldview, cultural, and social structure factors of technology, religion and philosophy, kinship, cultural values and lifeways, politics and law, economics, education, environmental context, language, and ethnohistory (see Appendix A). Diversities and universalities that may exist in the generic and professional care meanings and practices of Finnish women in birth were also important to identify. The theory with the Sunrise Model was the conceptual framework to discover care meanings and practices of Finnish women in birth. Discovering emic, indepth, and holistic epistemic and ontologic care about Finnish women in birth was held as essential to know and understand the domain for this investigation.

Concomitantly, Leininger's three theoretical modes of care actions and decisions to provide culturally congruent care needed to be systematically

discovered to arrive at culturally congruent care. The three predicted modes were: culture care preservation or maintenance, culture care accommodation or negotiation, and/or culture care repatterning or restructuring of generic and professional caring. These modes were viewed as essential to document their importance related to the domain of inquiry and to develop culturally congruent care. Most importantly, the theory of Culture Care with the researcher's domain of inquiry, could provide new insights or reaffirm existing knowledge in maternal-child care in nursing and provide substantive transcultural nursing knowledge for the discipline.

Assumptive Premises

Certain assumptive premises within the theory of Culture Care were formulated in relation to the researcher's domain of inquiry. These premises have been developed to discover transcultural nursing care knowledge and phenomenon. The following assumptive premises, derived from Leininger's theory but modified to focus on the domain of inquiry were:

1. Human cultures have generic care meanings and practices and usually professional care meanings and practices for women in birth which vary transculturally.

2. Generic (emic) and professional (etic) care meanings and practices for women in birth are influenced by worldview, cultural and social structure dimensions, ethnohistory, and language within cultural contexts.

3. Cultural care meanings and practices for women in birth reveal differences (diversities) and similarities (universalities) among Finnish women.

4. Generic and professional care meanings and practices are essential to discover beneficial and healthy care practices for women in birth.

5. Beneficial and healthy care practices that are culturally congruent can contribute toward the health and well being for Finnish women in birth.

6. The three modes of actions and decisions within Leininger's theory can guide nurses to provide specific care to Finnish women in birth.

Orientational Definitions

In ethnonursing qualitative research, orientational definitions are used as key terms to facilitate open discovery. Most of these orientational definitions for this study were derived from Leininger's work and were used in this investigation:

1. Care refers to an abstract and concrete phenomenon related to assisting, supporting, or enabling experiences or behaviors toward or for women with evidence for anticipated needs that lead to a greater sense of well being in their birth experiences (derived from Leininger, 1995).

2. Caring refers to actions and activities directed toward assisting, supporting, or enabling women with evident or anticipated needs that lead to a greater sense of well being in their birth experiences (derived from Leininger, 1995).

3. Culture refers to the learned, shared, and transmitted values, beliefs, norms, and lifeways of women in birth that guides their thinking, decisions, and actions in patterned ways (derived from Leininger, 1995).

4. Cultural Care refers to the cognitively learned and transmitted generic

and professional values, beliefs, and patterned lifeways that assist, facilitate, or enable women in birth to achieve a greater sense of well being (derived from Leininger, 1995).

5. Emic refers to a woman's expression of her birth experience based on her own folk or lay viewpoint.

6. Etic refers to a woman's interpretation of her birth experience based on the researcher's perception of it.

7. Generic Care refers to emically learned and transmitted lay, indigenous, or folk knowledge and skills used to provide care for women in birth (derived from Leininger, 1995).

8. Professional Care refers to largely etic, formal, and cognitively learned professional care knowledge and practice skills obtained through educational institutions that are used to provide care for women in birth (derived from Leininger, 1995).

9. Cultural Care Diversity refers to the variabilities and/or differences in meanings and practices of care that are related to the care of women in birth (derived from Leininger, 1991a).

10. Cultural Care Universality refers to the common, similar, or dominant uniform care meanings and practices of care that are related to the care of women in birth (derived from Leininger, 1991a).

11. Culturally Congruent Care refers to those cognitively based assistive, supportive, facilitative, or enabling acts or decisions that are designed to fit with the cultural values, beliefs, and lifeways of women in order to provide

meaningful, beneficial, satisfying care in their birth experiences that leads to health and well being (derived from Leininger, 1995).

12. Women in Birth refers to the humanistic, naturalistic, and holistic birth experience of women that is culturally constituted and influenced by body, mind, and spirit.

13. Finnish refers to individuals who are born and raised in Finland and who identify themselves of Finnish heritage.

14. Well being refers to sense of contentment and wholeness that is beneficial and satisfying to one's state of health.

CHAPTER II

Review of the Literature

Part 1

The following literature review is organized and presented with respect to the researcher's domain of inquiry and demonstrates the importance of building knowledge in transcultural nursing and culturally congruent care of women in birth.

Transcultural Nursing and Birth

As early as 1955, Dr. Leininger began her pioneering work to develop within the nursing profession a theoretical and research foundation for the field of transcultural nursing. This field builds upon the anthropological and nursing care perspectives of the "holistic view of man through time and space, focusing upon scientific and humanistic nursing and health care needs" (Leininger, 1994, p. vii). As founder and leader of this specialized body of nursing knowledge, Leininger states that the globalization of transcultural nursing is a moral, human, professional, educational, and practice mandate.

In order for nurses to develop and expand their knowledge about transcultural nursing being a worldwide phenomenon, they must expand their worldview from a narrow, local perspective to a worldview of nursing that shows concern for and interest in diverse cultures. "Globalization implies an ethical and moral obligation for professional nurses to enter and function in a worldwide community" (Leininger, 1992, p. 2).

To date, there have been several transcultural nursing research studies

focused on maternal-child and birth care meanings and practices in different cultures. The first transcultural nursing study on birthing and child-rearing throughout the lifecycle was by Leininger with the Gadsup Akunans of the Eastern Highlands of New Guinea as reported in subsequent sources (Leininger, 1970, 1978, 1985, 1995). Leininger's work with the Gadsup to study the meanings, expressions, and lived experiences of human care which included the lifecycle event of birth was the first transcultural nursing study done by the first graduate professional nurse anthropologist (Leininger, 1970, 1978, 1991a). This ethnonursing and ethnographic study revealed that generic (folk or indigenous) care practices prevailed in the birthing and lifecycle process. There were no professional nurses or care practices in existence. In most cultures today professional nursing exists; however, generic care is limitedly recognized and studied. This study was a breakthrough in nursing and became the first transcultural nursing study based on the rudiments related to the evolving Culture Care theory and the ethnonursing method.

Beverly Horn, an early transcultural nurse specialist in maternal-child nursing speaks to the challenge for nurses to include care in nursing practice with the study of the Muckleshoot natives in the Northwest United States (Horn, 1978). She focused on how a particular group of Native American Indian women perceived the meaning of care in a caring relationship and looked at the phenomenon of care perceived as helping. She focused on how the women saw differences in roles of various health care providers and whom they perceived were most helpful and caring during pregnancy. Horn elicited many

beliefs and values about childrearing and caring from the emic, or Muckleshoot's inside views, about care and care values. She discussed the concepts of imbalance and the state of pollution with resultant practices that may be of concern to many women of diverse cultural groups. She believed that all cultures have explanatory models for health and illness and that the conceptual structure of these models was essential knowledge for nurses who provide culturally sensitive care. "It is essential during all phases of the maternity cycle but especially during the postpartal phase, that nurses provide care based on knowledge of and respect for the lifeways of people from unfamiliar cultures" (p. 50).

Although an understanding of the postpartal phase was clearly important, the actual birth, the time during which imbalance and pollution begin, was also crucial to the understanding of caring expressions, patterns, and practices. This work held promise for comparison of various cultures in order to discover the caring expressions, patterns, and practices of women. A conceptual framework, one that examines cultural influences, however, was needed to explore the care meanings and practices from the emic as well as etic perspective.

Culture Care theory with a focus on the worldview, ethnohistorical factors, social structures, and folk health and illness beliefs and practices of the American Hare Krishnas was used by Morgan (1992). As a transcultural nursing specialist, she discovered ways that transcultural nurses can provide care to Hare Krishna women. Emphasis in this study was on the cultural care

values, beliefs, and practices related to pregnancy and childbirth. The Hare Krishnas' stringent and disciplined lifestyle demonstrated the importance of culturally congruent care as essential to the Hare Krishna pregnant mothers and in their birthing lifeways.

In addition to the Hare Krishna women, Morgan completed a comparative study of prenatal care of urban and rural African-American women. Her findings revealed four dominant themes about prenatal care and health: 1) the importance of cultural care for their well being included protection, presence, and sharing, 2) the social structure factors of spirituality, kinship, and economics were major influencers on care, 3) health care in the prenatal period was advantageous, and 4) their folk health beliefs and practices influenced well being (Morgan, 1994). These studies reaffirmed the need to build and use transcultural care knowledge on pregnancy and birth of cultures within the United States.

Using Leininger's theory of Culture Care, Bohay (1991) discovered that pregnancy and birth phenomena of the Ukraine was limited. Her study focused on discovering pregnancy and birth care of Ukrainians. The rationale and significance of her study was to identify lifeway patterns in order to guide nurses in providing culturally congruent care. The methods of ethnonursing and life history were used to discover the care meanings and experiences. These expressions were found to be embedded in a religious, worldview, and kinship orientation. They were closely related to family and community obligations, were strongly evident in female actions and decisions, and were

reflected in the values of family presence, closeness, support, and helping others. The expressions were found to exist with younger adults acculturated in the American culture in contrast to older Ukrainians (p. 224).

Kendall (1977), an early transcultural nurse midwife who studied Iranian women and family life, did an exploratory, descriptive, ethnographic study of socialization practices and family structure which revealed information on the role of women in the Iranian culture. The data included social structure factors such as historical, religious, economic, political, and familial dimensions that are identified in Leininger's Sunrise Model. However, two non-nursing theoretical frameworks were employed, that of psychoanalytic psychology and behavioral learning theory. Despite the theoretical orientation, the findings from the use of the ethnographic method are important to transcultural nursing and the challenge for nurses to provide nursing care with respect for a cultural group's needs, beliefs, and values.

Finn (1993), a transcultural nurse specialist and childbirth educator, conducted a phenomenological study focusing on the discovery of the meanings of care/non-care of women in birth. Using Leininger's theory, she investigated generic and professional, caring and noncaring meanings and expressions. She found recognizable differences between professional nurse care and generic care supporting Leininger's work. "The obvious as well as the covert or embedded patterns of generic and professional nurse care expressions" were identified (p. 180). Finn found that "the nonverbal expressions and attitudes of the nurse were crucial in whether the nursing care

was interpreted by the informants as care or noncare" (p. 233).

This research serves to direct clinical practice so that nurses throughout the world can use scientific care knowledge as a firm base on which to build their practice decisions. This study as well as Morgan's, Bohay's, and Kendall's demonstrates the value of transcultural nursing research, the use of a theoretical framework, and the strength of the ethnonursing method.

Transcultural Nursing

Andrews (1992) emphasized the importance of nursing care keeping pace with population and health care trends that draw upon not only knowledge from the physical, natural, and behavioral sciences, but also from research-based theories of transcultural, cross-cultural, and international nursing. She claimed that a framework of transcultural nursing could meet the needs of culturally diverse people, identify current trends in transcultural nursing, and suggested ways in which nurses can prepare for increasingly diverse individuals in the future.

In Andrews and Boyle's (1995) work Transcultural Concepts in Nursing Care, they presented transcultural nursing as a synthesis of concepts from nursing and other disciplines, anthropology, sociology, and biology. They stressed the need for changes in nursing to reflect the dynamic changes that are taking place not only in the United States in terms of health care reform but internationally as well with new nations emerging and old ones either undergoing evolution or disappearing altogether. The authors are committed to the goal of improving care through transcultural practice and continue their

efforts toward the development of a research-based theoretical framework relevant to transcultural nursing practice.

The view that nursing practice cannot be ethical unless the culture and beliefs of the client are taken into consideration was presented by Eliason (1993). Butrin (1992) emphasized the importance of understanding culture by identifying three major themes from her study that examined encounters between nurses and clients from diverse cultures: mutual satisfaction, incongruent perceptions of the encounter, and mutual dissatisfaction. These themes were previously supported by research on mutual caring and transcultural nursing. These authors supported the need for building transcultural nursing knowledge and demonstrated a commitment to culturally congruent care; however the findings were limited in the use of culture care theory.

Women in Birth

The focus of nursing care to support women in labor can no longer be exclusively on ensuring a safe birth but must also be on creating a positive and satisfying birth experience, that contributes to health and well being. Various studies done by nurses have focused on the helpfulness of nursing behaviors that meet women's tangible needs, emotional needs, and the need to be involved in the decision-making of the birth experience.

Using social support as a conceptual framework to explore women's perceptions of nursing support in labor, Kintz (1987) found that affect, affirmation, and aid were the key ingredients. She defined affect as

expressions of admiration, respect, liking, or love (p. 127). Affirmation signified agreement or acknowledgment of rightness of another person's actions or statements. Aid was the provision of direct assistance such as money, information, time, etc. This is particularly relevant to women in birth because nurses need to accept and acknowledge women's expectations and behaviors during labor. Nurses also need to affirm women's self-worth and provide them with necessary information for this significant life event. Nevertheless, the need still remains to examine these aspects within a cultural framework.

In a study by Hodnett and Osborn (1989), three variables were found by nurses to predict perceived control during birth: expectations of control, the presence of a continuous professional caregiver, and pain medication usage. The results demonstrated the importance of the professional nurse during childbirth. Professional support was conceptualized as having four dimensions: emotional support, informational support, tangible support, and advocacy (p. 291). Shields (1978) found that the most important supportive behavior was the nurse's ability to assess and meet the women's need or lack of need for the nurse's presence during labor.

The next most helpful categories of supportive behavior included teaching and providing reassurance, comfort, and concern. Cartwright (1987) described the characteristics of care that were perceived by her professional views as kindness and understanding. This care included providing explanations and information, keeping pain and discomfort within the woman's expectations, providing the opportunity for the mother to hold the newborn immediately after

birth, and encouraging a support person to be with her. This study was focused on the Euro-American culture and not all cultures value these attributes of care.

In an effort to determine which nursing support behaviors were most helpful in assisting women to cope with labor, maternal nurses Bryanton, Fraser-Davey, & Sullivan (1994) identified the most helpful behaviors as making the woman feel cared about as an individual, giving praise, appearing calm and confident, assisting with breathing and relaxing, and treating the woman with respect. They concluded that nurses can assist women to cope with the stress of labor. However, nurses need to use a high degree of interpersonal skills in their care in addition to being technically competent. The cultural influences of caring, whether professional or generic, were limited in these studies and most were focused only on one culture, thereby having insufficient use transculturally.

Personal control or mastery has been found to be a key component of birth satisfaction (Butani & Hodnett, 1980). In promoting long term satisfaction with childbirth, caregivers were advised to attend more to prenatal expectations than to transient, impulse-driven desires during labor (Christensen-Szalanski, 1984).

> The process of labor and delivery and a woman's satisfaction with her experience of childbirth have been related to a number of variables, including the extent and type of her antenatal preparation, her perception of the environment in which she gives birth, and the support she receives from her partner, her doctor, and the medical staff (Bennett, Hewson, Booker, & Holliday, 1985).

Studying parent satisfaction with labor and delivery care, Field (1987) found

that nursing care was the key element in influencing satisfaction. Nursing behaviors identified by the parents included making the parents feel that their care was personalized, conveying a feeling of respect, being matter of fact, encouraging the parents, telling the mother she had done well, and making the couple feel at ease. Also identified were behaviors such as providing distractions, being friendly, demonstrating knowledge, responding to questions, listening to and respecting the mother's opinion, introducing themselves, and providing continuity of care. These resources provide us with relevant knowledge for the care of women in birth, but are limited in their usefulness for women of various cultures.

Humenick (1992),a popular nurse author, states, "Women emerging from birth experiences with a sense of mastery and competency gained through using their own personal resources have been shown to have increased self-esteem and self-perception" (p. 64). The coping strategies with the highest mean scores for perceived effectiveness during childbirth were found to be labor companion support, pushing techniques, information, breathing techniques, relaxation, and birth choices (Koehn, 1992). Maintaining control throughout the birth experience and having physical and/or emotional support provided appear to be common themes to many studies regarding women in birth and their sense of well being. However, these nursing studies primarily examine only one culture, tend to be limited, and perhaps examine a mix of many cultures. Because of this, assumptions are formulated, generalities made, and true cultural caring practices of women in birth often lost.

Anthropology and Birth

In her book, Birth in Four Cultures, Jordan (1993), an anthropologist, asserts that crosscultural investigation of childbirth caring practices would be desirable because the range of human physiological and behavioral variability can be examined, the appreciation of organized female networks can be improved and broadened (since birth in most societies is women's "business"), and a better understanding of the birth process could be gained. Kay (1982), a nurse anthropologist, writes in Anthropology of Human Birth that "women's health care in every society is a reflection of the total culture" (p. vii). She claims that each childbearing system relates to the social organization, the political system, and the religious system as much as it does to the medical system of a particular society and that the values and beliefs are reflected in the practices that they maintain. It is important for professional care givers to be aware of not only what the cultural diversities in birth are but also to understand the source of their variation.

Birth in the United States appears to be increasingly scrutinized due to the still unfavorable rates of perinatal mortality and morbidity. Changes in maternity care are needed to shift from outcomes based largely on medical-statistical evidence to quality care indicators that include a growing recognition of the position, competencies, and caring needs of women. These changes will produce a significant enhancement of maternal well being because they reduce the "dissonance between the woman's conception of herself and the treatment she is accorded" (Jordan, p. 141). This critical examination of

childbirth in the United States further substantiates the urgent need for transcultural care knowledge of diversities and universalities in birth practices.

The anthropological literature states that across all cultures and throughout history, humans have used specific rituals as rites of passage in order to transmit cultural beliefs and values (van Gennep, 1960). His discussion of cultural rituals as mechanisms for helping people move from one life cycle to another focused on three phases: rites of separation, which removed the individual from the previous situation; rites of transition, which assisted movement to a new stage; and rites of incorporation which provided integration into the new stage.

Davis-Floyd (1992) claims that there is a surprising standardization of medical procedures for birth in the United States that are similar to the rituals of traditional societies. She contends that these hospital procedures are ritual responses to extreme fear that Western society has of the natural processes of birth. "Cumulatively, routine obstetrical procedures such as intravenous feeding, electronic monitoring, and episiotomy are felt by those who perform them to transform the unpredictable and uncontrollable natural process of birth into a relatively predictable and controllable technological phenomenon that reinforces American society's most fundamental beliefs about the superiority of technology over nature" (p. 2).

A ritual is defined as "a patterned, repetitive, and symbolic enactment of a cultural belief or value; its primary purpose is transformation" (p. 8). Webster (1990) defines ritual as "a set form or system of rites" (p. 508). These

definitions contrast with a standard which is defined by Webster as "something established for use as a rule or basis of comparison in measuring quantity or quality" (p. 575). Standards of care identify the basic expectations and functions for nurses which serve as a basis for accountability in nursing practice. Olds, London, and Ladewig (1996) state, "because health care settings vary from one region to another, standards are used as a basis for developing individualized policies and protocols" (p. 25). Most nurses recognize the importance of and adhere to standards of practice; however, may have a "negative view of rituals as being too rigid, too conforming, and non-flexible rules or laws" (Leininger, 1995, p. 133). Nevertheless, nurses practice many rituals of care that often go unrecognized.

Davis-Floyd (1990) states that rituals have salient features which include: 1) the symbolic nature of ritual's messages; 2) its emergence from a cognitive belief system; 3) its rhythmic repetition and redundancy; 4) the cognitive simplification that ritual produces in its participants; 5) the cognitive stabilization that ritual can achieve for individuals under stress; 6) the order, formality, and sense of inevitability in ritual performances; 7) the acting, style, and staging that give ritual high drama; 8) the climax that heightens ritual's emotional impact; 9) the cognitive transformation of its participants; 10) ritual's importance in preserving the status quo; and 11) ritual's paradoxical effectiveness at achieving social change. These characteristics could be predicted to occur in women's birth experiences transculturally; however, how, why, and what meanings have yet to be documented and systematically

studied. Realizing the importance of consistency and the value that women in birth place on performance of rituals attest to the need to explore and discover the rituals of generic and professional care meanings and practices for women. This is essential to nurses' understanding related to providing culturally congruent care.

Ethnohistory of Finland

These findings illustrate some of the cultural care needs of women in birth, and also serve to reveal the generic and professional care meanings and practices that are important for their well being. For Finnish women, these care meanings and practices are best explicated when examining Finland's health care services. Municipal health centers provide free medical care and lab tests; sickness insurance and voluntary insurance plans reimburse a large part of the charges for private health care (National Account of the Research Institute of the Finnish Economy, 1992). "Prenatal clinics have been part of Finnish maternity care for decades" (p. 9).

Educating the general public regarding the importance of early prenatal care is a priority. In a study conducted on a large number of primiparous women in Finland, the results indicated that low childbirth knowledge is associated with a poor pregnancy outcome. This study supported the need for support, supplementary education, and careful obstetric surveillance (Rautava, Erkkola, & Sillanpaa, 1991).

According to the Ministry of Social Affairs and Health (1995), "around 99% of women attend maternity clinics for examination during the first four months

of pregnancy and must indeed do so if they wish to qualify for maternity benefit" (p. 38). Expectant women in Finland receive a maternity care package which contains basic baby clothes and accessories and a monthly stipend if prenatal care is sought before 16 weeks gestation (Carr, 1989). According to Locock and Clark (1989),

> The Finns seem very willing to present themselves for treatment, and respond well to health education and screening programs. This may be partly because compliance with authority is seen as a national characteristic, noticeable in other spheres of activity apart from health care. However, this characteristic is often supplemented by the skillful use of incentives and persuasion on the part of the authorities, a good example of this being found in ante-natal services (p. 18).

A child benefit is paid by the state for each child and maternity leave lasts for about one year. These indicate the value that the country has for strengthening the new family through quality health care.

Finnish education has a focused program that emphasizes sexuality in its curriculum which starts in the early elementary years. "Finnish sexual attitudes reflect an open and rational outlook on sexuality, which is considered a normal part of life beginning with childhood" (Kontula, Rimpela, & Ojanlatva, 1992, p. 76). Contraceptive education naturally begins in adolescence which is then followed by prenatal education; these concepts are considered a natural progression of health education.

Being sexually active as a teenager is considered acceptable; however, the incidence of teen pregnancies is low (Carr, 1989). A long term study administered to 13, 15, and 17 year olds in Finnish public schools found that for the most part knowledge level was satisfactory and with increasing age,

most attitudes showed increasing tolerance towards sexual matters and liberalism (Kontula, Rimpela, & Ojanlatva, 1992).

Nurse-midwives play an important role in prenatal care for low-risk expectant women. In a report on the variation in obstetric interventions by midwives, the study finds that the skills, attitudes, and routines of midwives may explain part of the variation in birth interventions. "Because of their cost and adverse effects, interventions are to be avoided unless they contribute to better health outcomes" (Hemminki, et al, 1992, p. 85). Prematurity is about three percent; the infant mortality rate is six percent per 1000 live births, ranking third (after Japan and Sweden) of 39 countries (World Health Organization: World Health Statistics Annuals, 1990). In a special report on Obstetrics in the United States prepared for the International Childbirth Education Association entitled The Cultural Warping of Childbirth, Haire (1972) explained that, generally, the differences in infant survival among various cultures lie in "our frequent use of prenatal and obstetrical medication; our pathologically oriented management of pregnancy, labor, birth, and postpartum; and the predominance of artificial feeding in the U.S." (p. 4).

Carr (1989), a nurse researcher who completed an observational experience in Finland, identified two factors that contribute to Finland's low infant mortality rate: incentive for early antepartal care and public education. The typical birth experience as described by Carr holds similar professional caring practices as those of the United States, i.e., prenatal diagnostic technologies, routines, and procedures. The literature, however, does not

examine care with regard to the generic caring practices and especially in terms of a transcultural nursing perspective. The care meanings and practices, generic and professional, if known, might be compared to women of various cultures so that one could determine what contributes to a greater sense of well being and health in women worldwide.

Brown (1976) emphasized the importance of exploring the birth experience transculturally in the following statement:

> When nurses work with women of another culture, it is important to understand their beliefs and value systems; . . . there are many benefits to be derived from looking at the similarities and differences between how various cultures view and handle the childbearing cycle (p. 35).

Horn (1990), a transcultural nurse specialist, speaks to the importance of meeting the health care needs of those from different cultures, especially in the United States into which new cultures constantly enter. She states that the childbearing process in particular poses a great challenge for nurses and discusses nursing implications that have evolved from two cultural, folk (generic) beliefs held by many cultures. They are firstly, "that delivery has upset the balance of the mother's body"; and secondly, that "the mother, infant, and those caring for them are in a state of pollution" (p. 49). Horn states that it is imperative that nurses provide care based on knowledge of and respect for the lifeways of people from unfamiliar cultures. These ideas offer an exciting challenge for nurses to explore and discover transcultural nursing and clearly indicate the need for further research on other cultures.

As Humenick (1981), Professor of Nursing at the University of Wyoming, states, "Birth for many women has become biologically safe yet psychologically

a dehumanized, unsatisfying, and disempowering experience" (p. 80). However, if nurses could provide culturally congruent care, care that helps women of all cultures utilize generic as well as professional care meanings and practices, this care would contribute to their health and well being. Thus, the care meanings and practices of Finnish women in birth are influenced by many factors - factors most easily studied with the tenets of Cultural Care theory and use of the Sunrise Model to identify holistically the dimensions that influence their health and well being.

Review of the Literature

Part 2

Ethnohistory

A brief ethnohistory is presented to gain an understanding of Finnish culture relative to the domain of inquiry. Finland is one of five Nordic countries: Iceland, Sweden, Norway, and Denmark. It is the sixth largest country in Europe but considers itself first a part of the Nordic community, then part of Europe. The Nordic countries share a joint labor market with uniform benefits for all Nordic citizens regardless of nationality, i.e., one passport allows for travel to all Nordic countries. The Nordic countries have recently taken measures towards consolidation with the European Union, a joint European economic arena for the purpose of free exchange of goods and services among its members. With the exception of Norway, the Nordic countries voted to become members of the European Union. Effective January 1, 1995, Finland has officially become a part of this organization.

Finnish companies have prepared for this single European market by increasing industrial footholds abroad. Finland is a neutral country and works toward ensuring world peace by actively taking part in the United Nations. Finland is a chosen member of the United Nations Security Council and many Finnish soldiers have served in peacekeeping forces worldwide. The Finns have lived in the northern part of Europe for 4000 years before gaining independence in 1917. Early foreigners who came to this area of the far north considered Finland a mysterious country. Natural barriers separated Finland from other countries, i.e., the sea, the wilderness, their language. Their isolated position on the periphery of Europe has made Finns culturally a homogenous people.

Sweden incorporated parts of western Finland in the twelfth century which continued for over 600 years but was considered to be one endless battle. In twelve major wars in which the eastern border was moved seven times, Sweden fought with Russia over Finland until 1809 when Finland was joined to Russia as an autonomous grand duchy. Under Russian emperor Alexander I, the country was allowed to retain its constitution and Lutheran religion (Sauri, 1992). This later became significant in preserving its administration and social structures for independence.

Despite Finland's domination by Sweden and Russia, Finland never lost its identity. After proclaiming independence, the country fell subject to the Civil War of 1918 in which the "whites" (supported by Germany) fought the "reds" (supported by Russia). The Winter War of 1939-40 then ensued with the

Soviet Union attacking Finland which was then followed by the Continuation War of 1941-44 where Finland fought as Germany ally, then against Germany to clear the country of German troops. Despite these wars, Finland was never occupied at any stage, never had to surrender, and its capital Helsinki was one of few European capitals that were not taken. This history of turmoil and control have led Finns to establish a sense of duty or devotion to their country's independence - a precious commodity after years of struggle. As Rajanen (1981) described, "This feeling has sustained the Finns in fighting forty-two wars with Russia and losing every one. It's the hard-jawed integrity that makes them pay their war debt when wealthier nations repudiate their obligations" (p. 10). Finland's rich and distinctive folklore and traditions have been attributed to helping the Finns survive these turmoils of history. Isolation has made Finns introspective. As Sauri states, "It is not very easy to get close to a Finn, but once you do get to know him, he makes a trusted friend" (Sauri, p. 2).

Cultural and Social Structure Dimensions of Finland

Leininger's Theory of Culture Care Diversity and Universality challenges the researcher to discover transcultural human care knowledge and understand the importance of culturally congruent care. Leininger's (1991a) Sunrise Model is designed to depict various dimensions of the theory. It is to be utilized as a cognitive map to "orient and depict the influencing dimensions, components, facets, or major concepts of the theory with an integrated total view of these dimensions (p. 49). According to the model, the social structures are

technological, religious and philosophical, kinship and social, cultural values and lifeways, political and legal, economic, educational, environmental context, language, and historical in nature.

Utilizing this model to explore and discover the Finnish system of birth appears to be an important means to discover the diverse influences of this culture - the totality of the Finnish women's health and well being during the life cycle event of birth. Each dimension will be examined in terms of the Finnish culture, more specifically for Finnish women in birth. This beginning focus might serve as a basis for comparison of other cultures. An indepth study of the Finnish culture can only contribute to transcultural nursing knowledge that underlies culturally congruent care - "care that is beneficial, satisfying, and meaningful to the people" (p. 41).

In keeping with Leininger's theory of Culture Care and to understand women in birth within the cultural context, the technological, religious and philosophical, kinship and social, values and lifeways, political and legal, economic, and educational factors will be discussed. The close, neighborly relationship with the Nordic countries has strongly influenced Finnish cultural and social structure dimensions.

Technological Factors

Finland is proud of its highly developed science and industries (Sauri, 1992). The electronics industry has grown at a tremendous rate and is evidenced by their development of technology and enterprise parks that work in close cooperation with universities to advance the high-level technical

products and services. Finnish technological sciences have been developed to a fine art. The mobile telephone and paging systems made by the international company Nokia are among the best-selling products in the world. Nokia is Europe's largest and the world's second largest mobile phone manufacturer. The company has sales in approximately 70 countries and joint ventures in 16 countries (The Research Institute of the Finnish Economy, 1992).

Finland's great concern for health technology is shown in its effective health services and care, extensive national sickness insurance, five medical schools, five nursing doctoral programs, and widespread primary health and dental care policies. With a history of being committed to science and learning, Finland's health services clearly match those of other technologically advanced nations (Rajanen, 1981).

Religious and Philosophical Factors

Finland's cultural heritage has deep roots in religion and philosophical factors that influence the people's lives (Rajanen, 1981). Historically, Christianity, made its way into Finland through the many military crusades sent by Swedish kings for the purpose of "demonstrating to erring people that they had better be good Christians" (p. 26). The Finns surrendered because they were ready to have a working relationship with Sweden in defense against Russia. During what is referred to as the Stockholm Bloodbath, Christian II of Sweden launched a series of persecutions of any person thought to be his opposition.

Out of this turmoil arose a young leader Gustavus Vasa whose mother and

sister had died in Christian's dungeons. He escaped and rallied the oppressed; he soon had an army that challenged Christian's, was elected king and declared himself to be heir to the duke of Finland. He dissolved the relationship with the Catholic church and established Lutheranism in Sweden and Finland in 1527 (Lewis, 1994). The bishops of Turku (one of the oldest cities), studied in the universities of Europe and sent the city fathers as young men to prepare them to serve their nation.

Nearly 90% of all Finns are Evangelical-Lutheran; only 2% are Finnish-Orthodox. Nevertheless, a strong Orthodox influence is evident in the 200,000 people that visit their monasteries to witness the practices of traditional religious rituals (Central Statistical Office of Finland, 1992). According to Rajanen (1981) the church in Finland does not depend on Sunday contributions. "Actual church attendance is about 2% because the church is state supported" (p. 85). The Finns have always believed in a spiritual existence outside of themselves.

The early Finns relied on a shamanistic faith called animism which entails a reliance on wizards and the belief that each created thing has a spirit of its own. Early Finns simply asked politely to have certain needs met, without sacrifice; "it was a very comforting religion for people with plenty of difficulties of their own" (p. 86).

The word *sisu* is meaningful in terms of Finnish philosophy. *Sisu* refers to a concept of life at best expressed by Rajanen who states, "I may not win, but I will give my life gladly for what I believe" (p. 10). It stands for a philosophy that

what must be done will be done. *Sisu* represents the optimistic courage that sustained the Finns in fighting 42 wars and losing every one. It is their strongest national characteristic and sets them apart with their unforgiving will.

Kinship and Social Factors

All the Nordic countries have recognized for some time the equality of women and so the kinship structure of Finland reflects this egalitarianism (Rajanen, 1981). Women in Finland have traditionally held control of their own inheritance. Women did not take their husband's name in marriage until the eighteenth century. Earlier, women remained members of their own fathers' families and only children took their husband's name (Rajanen, 1981). These beliefs have allowed the status of women in the Nordic countries to progress politically, socially, and economically.

Family life in Finland is highly valued. This is evident in the traditions of family holidays in the country, the lifeways of family involvement in open-air theaters, festivals, exhibitions, and concerts, and the custom of adhering to family traditions during holiday celebrations. Because Finland was for so long an agrarian society, the nuclear family was a vital unit and the values instilled by the family have traditionally been strong (Peltonen, 1994). "Not only were family members the best company for each other in often isolated farming areas but the children inherited the parents' land" (p. 67).

Day care is modern and subsidized by the government; nearly half of Finland's children are enrolled in public day care centers. Progressive laws guarantee 10 months fully-paid leave for either mother or father who stays

home with the newborn and this time can be extended (Peltonen, 1994). These laws allow more new parents to stay at home in the crucial early stages with the infant. With a low birth rate of 1.7 children for every two adults, an increased number of elderly, and a shrinking workforce, attention is often strongly focused on children (p. 67).

Cultural Values and Lifeways

The Finnish culture has many distinct cultural values rooted in the ethnohistory and lifeways of the people. By examining the Finnish people's fundamental changes in care values, Nikkonen (1994) was able to study how this affected the care of patients. She reports that in the mid 1980's, "materialism, safety, and tradition had become less valued, whereas meaningful work, social relations, and individualistic self-realization had become increasingly important to the Finnish people " (p. 13).

Leininger, a nurse anthropologist, identified from her research several cultural values and care meanings of Finnish-Americans. The care values which were supported from key and general informants from Northern and Southern Finland were: 1) enduring hardships, 2) being frugal and watchful, 3) being productive, 4) maintaining neutrality, 5) being nonpunitive, 6) keeping beliefs, 7) maintaining national pride and traditionalism, 8) quiet action, 9) maintaining proper rituals and decorum, and 10) belief in folk and modern healing modes (Leininger, 1991a, p. 367).

One of the major cultural values of maintaining pride and traditionalism is evident in their literature, their cultural and applied art, and their entertainment

and leisure activities. Finnish literature is distinctive and it is often said that only Icelanders buy more books than the Finnish people. The national epic, Kalevala, is the national epic and considered one of the great epics of world literature. It is "closest to common man and least given to idealizing war and heroic deeds" (Sauri, 1992) and therefore, is considered a great source of strength for the Finnish people, i.e., "wise men and skilled craftsmen are the heroes of the Kalevala" (p. 17).

This appears to best illustrate their cultural values of knowledge and skill. A significant problem facing Finnish literature is that so few people of the world speak the Finnish language. Both Finnish theater and music have received international recognition. Olavinlinna, a famous castle site of Finnish opera, is considered the oldest testimony to Nordic influence, i.e., the Swedes commissioned a Danish knight to build it on Finnish soil in honor of a Norwegian king. Finnish art, architecture, and design are world famous, perhaps Alvo Aalto's Finlandia Hall in Helsinki being the most popular. Glass, porcelain, clothing, furniture, etc. are major exports, such as Arabia, Iittala, Marimekko, and Luhta.

Sports are another important part of the Finnish cultural value of maintaining national pride as evidenced in the many Olympic achievements which have helped contribute to the nation's identity. Paavo Nurmi "ran Finland onto the world map" (p. 23) with his nine Olympic gold and three silver medals. One of the more impressive features of Finland's love of sports is the variety in which they excel: track and field, cross-country skiing, alpine events, wrestling,

boxing, shooting, gymnastics, rowing, canoeing, orienteering, sailing, motor sports, and others. Leisure activities such as summer cottages, boats, and saunas appear to be an essential part of the "Finnish way of life" (p. 11). Their urge to own a cottage, sauna, and a boat is suited for their "land of a thousand lakes".

Since the sauna has been a part of Finnish culture for the past 2000 years, it is an important demonstration of the cultural value of maintaining proper rituals and decorum and of their belief in folk and modern healing modes. The function of the Finnish sauna and its origins are linked with the value of cleanliness. It is also physically and emotionally therapeutic and because of the feeling of euphoria that it elicits, may have some spiritual benefit. It has been practiced as a cultural lifeway for thousands of years as a healing and caring practice for self and others. The sauna has even existed as the place of birth for many Finns. A Finnish proverb states, "First you build the sauna and then the house" (Borgia, 1994, p. 223). The sauna is considered a national institution numbering easily over one million in a country of five million.

Although it is not a Finnish invention, it is the Finnish development of an ancient European bath culture and it has acquired a distinctive Finnish character. Hillila (1988) states, "the sauna is one of Finland's finest gifts to America and the world. It promotes vibrant health, thorough cleanliness, and drugless relaxation" (p. 1). Therefore, there is more to the sauna than just getting clean. It is a time to leave titles and positions in the dressing room and enter to meet friends and socialize. In using the sauna, the Finn is holding onto

a wholesome, mind-soothing, health-restoring ritual (Rajanen, 1981).

Political and Legal Factors

Finland is a republic and a multi-party (8) democratic country but the president has a strong position as he appoints government, can dissolve Parliament, call for new elections, direct foreign policy, ratify laws, serve as chief of defense, etc. Parliament is of one house with 200 members, each elected for four year terms. It makes the laws, but they are not official unless the president signs them. Representation is in proportion to population.

Finnish women were the first women in Europe to gain the right to vote in 1906; there are more women in Finnish Parliament than anywhere else in the world: 77 of the 200 are women, seven of the 17 ministers in Finnish government are women (Central Statistical Office of Finland, 1992). Finland has recognized the equality of women in terms of employment as well as political participation. Many women are held in high esteem having reached success in the professions requiring skill instead of strength.

Having no military alliance, Finland is a neutral country engaged in policy aimed at peaceful coexistence. The Conference on Security and Cooperation in Europe, held in Helsinki in 1975, gave rise to the "spirit of Helsinki" (Sauri, 1992, p. 5). Although Finland has fought 42 wars with Russia and lost every one, the country remains stoically independent, perhaps attributable to their long-cherished sense of national identity. The nation has been defeated in war but never occupied and is now one of the most democratic and prosperous of nations.

Economic Factors

Finland is one of the richest countries in the world, but it is costly to live there. For example, the same amount of money buys one-fourth less goods in Finland than in the United States. In the past two decades, Finland's economic growth was only exceeded by Japan (National Account of the Research Institute of the Finnish Economy, 1992).

Forests are Finland's main natural resource, consequently the basis of the economy is created by the forest products industry and the related metal and engineering industry. Even though Finland has only 0.5% of the world's forest, it accounts for 5% of the world's output of forest industry products. The forest, wood-processing, and metal engineering industries are in leading positions of Finnish enterprise. Finland is the world's second biggest exporter of paper after Canada (Woolnough, 1994).

The shipbuilding industry is one of the best in the world with ferries, cruise vessels, deep-sea research vessels, and submarines requiring the most advanced technology Finland has to offer. Shipping is necessary year round and therefore, Finland is the world's biggest manufacturer of icebreakers which are crucial to keeping frozen harbors open. It would appear that this country is highly dependent on open harbors which are the people's gates to the world (Nickels, 1994).

Finnish people value a high standard of living for quality of life and as a cultural value is affected by taxation and public services. Income tax is progressive, i.e., as earnings rise, so does the tax rate. After direct taxes, the

largest sum collected in taxes comes from a purchase tax. Public services such as health care and welfare are on a high level in Finland. Municipal health centers provide almost free medical care and laboratory tests. Sickness insurance and voluntary insurance plans reimburse a large part of the charges for private health care.

Educational Factors

The belief that education in Finland is a duty, not a privilege, supports their value in learning and being productive. This philosophy may date back to an old church law of 1686 that forbade marriage to anyone who could not read, thereby forcing those who wanted to marry to get schooling first. The Finns regard education as vital to democracy. More than 18% of the national budget is allocated for education as compared to 8% for health, 6.9% for housing, and 5% for defense and administration (Rajanen, 1981). Finland has one of the highest literacy rates in the world. In 1978, the literacy rate in Finland was 99%. The goals of education are to "insure equal opportunity for all citizens and to improve the quality of life (p. 145). According to Neff-Smith, Lacatell, & Moore (1996), with high literacy rates among women, the infant mortality rates are reduced.

> Not only will literacy help women to redefine and expand their roles, but it will assist them in making solid family health and planning choices ... reductions in infant mortality and improved access to education combine to naturally reduce the number of children a woman chooses to have, as she seeks expanded roles for herself and has greater hopes of seeing the children she bears survive to maturity (p. 290).

Education is compulsory. Moreover, education is free, supported by government with tuition, books, and school lunches during the first nine years

of comprehensive education being provided without cost (National Account of the Research Institute of the Finnish Economy, 1992). Upper secondary school lasts three years and ends with matriculation exams that allow those interested students entrance to one of the 17 universities. Special schools designed for those students that are gifted in music, art, foreign language, or sports are available. The trend is to secure a vocational education for each young person before he/she enters the labor market, along with a broad, basic liberal education. In general, education has a very high cultural value in the quality of life, enhancing the health and well being of the people.

Environmental Context

The surface area of Finland is 338,145 square kilometers. As one of five Nordic countries, it borders Sweden to the west, Norway to the north, and Russia to the east (Sauri, 1992). The population of Finland is 5 million people, a sparsely populated country which averages about 16 inhabitants per square kilometer. Environmentally, Finland is known for its hundreds of thousands of lakes that formed by the continental ice sheet that covered northern Europe. Most of them are fairly shallow and interspersed by small islands. The southwest coast of Finland is an archipelago. The landscape varies from plains to a rolling lake district in central and eastern Finland and the fells of Lapland. There are few mountains and many forests which are Finland's main natural resource. Although it lies in the same latitude as Alaska or Greenland, the climate is similar to that of the northern United States, because of the warming effect of the Gulf Stream. Summers are the best tourist season and it is said

that "summer is short but not too snowy" (p. 11). Environmental problems do exist but Finland has what other countries lack: space, love of nature, clean water, silence.

Language and Worldview

Finland is a bilingual country with two official languages: Finnish and Swedish. Finnish bears no resemblance to any other existing language and has emerged intact from six centuries of Swedish rule. Many words of other languages that have a common root can offer some basic communication but Finnish is considered only the language of the Finns (Woolnough, 1994). This reflects their history of social and geographical isolation. Despite the language difficulties, English as a second language is spoken by a majority of Finns; therefore, interpretation of speech in basic communication is easily accomplished in even the remote areas (p. 88).

Because Finland is bilingual, both Swedish and Finnish schools are available. Foreign languages are started in the third grade; a third language can be chosen in the eighth grade (Sauri, 1992). Great emphasis is placed on languages not only because Finland is bilingual but because it is considered imperative to teach everyone a major world language so that contacts with the world are maintained. Hence, the worldview of the Finnish culture has and continues to be directed toward interacting with many different cultures through educational and language abilities.

Health Care System

According to Roemer, health systems throughout the world can be

classified according to the extent of governmental intervention that reflects political health policy. These policies are designated as "1) entrepreneurial, 2) welfare-oriented, 3) comprehensive, and 4) socialist" (1991, p. 95). Certain characteristics of Finnish health policy lead one to believe that although the government calls Finland a social-welfare state, its health policy is comprehensive. Similar to the welfare-oriented system in which governmental intervention has focused largely on financing personal medical care, but within a conventional pattern of health service delivery, Finland has carried this orientation further in that virtually all of the country's population is entitled to complete health service with all existent resources equally available to everyone (National Health Systems of the World, 1991). Entitlement to health services is viewed as a social right. With the 1972 Primary Health Care Act that fundamentally changed the pattern of delivery of ambulatory health services, a policy of high priority for primary care and decentralized management was instituted. The basic administration level became the municipalities which were directed by a local board of health. This principle strategy for health care delivery is through a nationwide network of health centers numbering 243 in 1994 (Health Care in Finland, Ministry of Social Affairs and Health, 1996), each of which serves about 20,000 individuals with a team of health care workers. The major source of economic support as described earlier is the general tax revenue collected by the local and national governments (80%). In 1993 Finland spent 8.8% of GDP on health care of which 77% came from public sources and 23% from private (ibid.). This

country's total population coverage, comprehensive services, and financing derived largely from general revenues has simplified administrative processes mostly because the system management is clearly visible to everyone and because it has reached a place of national importance politically. "The social soundness of a universal and comprehensive health service tends to be fully accepted, not being challenged by any significant political group" (Roemer, 1991, p. 218).

Therefore, health care in Finland is a social right and responsibility. According to the Women's Health Profile (Ministry of Social Affairs and Health, 1995), the general aim of health policy in Finland is to ensure social equity so that economic factors do not prevent the appropriate use of health services (Finnish Health for All 2000 Strategy). The Finnish women's right to receive high-quality health care is established by legislation (Act on the Patient's Right and Status). More that 99% of pregnant women use the maternity services in the health centers. These statistics indicate a commitment of the Finnish people to providing the best possible care to the health of women and children (Ministry of Social Affairs and Health, 1995).

CHAPTER III

Research Method

Ethnonursing Method

To discover the generic and professional care meanings and practices of women in various cultures, an appropriate method to study Finnish women in birth was the ethnonursing method. This method was chosen for the purpose of discovering the care meanings and practices of Finnish women within their natural setting from a culturological perspective. This method has been developed to fit the theory of Culture Care (Leininger, 1987, 1991a) and it permits the discovery of generic and professional dimensions of care in an inductively holistic manner. The ethnonursing method was designed to enable the nurse researcher to discover these dimensions of care meanings and practices of women through the emic perspective. Professional care meanings and practices of the nurse and generic care meanings and practices of the women were rigorously examined to identify, describe, and document a holistic, congruent approach to caring for women in birth.

Ethnonursing is defined as a

> qualitative research method using naturalistic, open discovery, and inductively derived emic modes and processes with diverse strategies, techniques, and enabling tools to document, describe, understand, and interpret the people's meanings, experiences, symbols, and other related aspects bearing on actual or potential nursing phenomena (Leininger, 1978, 1985a, 1990).

The purpose of the method is to discover new nursing knowledge as perceived and experienced by nurses. According to Leininger (1991a) there were no

appropriate nursing research methods that allowed the nurse researcher to "explicate and to know and understand the nature, essence, and characteristics of human care, and of actual or perceived nursing phenomena" (p. 75) before the development of the ethnonursing method. Leininger held that nurses, in order to make nursing scholarly and well-grounded, needed a research method to establish the discipline's humanistic, epistemic, and ontological bases that focus on human care.

General principles to support this research method have been developed by Leininger in order to guide the nurse researcher in its use. The first principle is for the researcher "to maintain an open discovery, active listening, and genuine learning attitude in working with informants in the total context in which the study is conducted." The second is that the researcher should keep an active and curious posture about the "why" of what is experienced. The third is to "record whatever is shared by informants in a careful and conscientious way for full meaning, explanations, or interpretations to preserve informant ideas." The fourth principle is for the nurse researcher to seek an experienced mentor; the fifth is to clarify the purposes of any additional research methods if they are to be combined with the ethnonursing method (Leininger, 1991a). Adherence to these principles has become evident as discussion continues relative to the study.

Enablers

The research process of observing, participating, interviewing, and validating data, involves the use of enabling guides as opposed to

measurement instruments found in quantitative research. Enabling guides, according to Leininger, help to explicate and facilitate open discussion and observation in the naturalistic environment of the informants (1991a). These guides included Leininger's Sunrise Model (see Appendix A), Lamp's Inquiry Enabler for Women in Birth (see Appendix C), Observation Enabler for Women in Birth (see Appendix D), Inquiry Guide for Ethnodemographic Information (see Appendix E), Leininger's Sequenced Phases of Observation-Participation-Reflection Enabler (see Appendix F), Leininger's Stranger to Trusted Friend Enabler Guide (see Appendix G), Leininger's Phases of Ethnonursing Analysis for Qualitative Data (see Appendix H), Generic and Professional Care Guide, the Coding Data System for the Leininger, Templin, and Thompson Field Research Ethnoscript (see Appendix I), and the Leininger-Templin-Thompson Ethnoscript Qualitative Software (Leininger, 1991a). The researcher developed her own enabler guides: Observation Enabler for Women in Birth, Inquiry Enabler for Women in Birth, and the Ethnodemographic Inquiry Enabler for use with women during and following birth. These guides were essential to the ethnonursing method in helping the researcher to study the collected data in a systematic manner.

Another research method employed was the use of audiovisual media, i.e., taking pictures in order to develop a photographic essay of each of the birth experiences. Audiovisual refers to various messages communicated to humans and others in different ways through all the senses. Visual expression through the use of photography was an extraordinary way to closely examine

the indepth feelings and emotions communicated by the women in their birth experiences. The photographs were used to gain more depth in discovering and understanding the care meanings and practices by means of another medium.

The generic and professional care practices provided to the women during each of their birth experiences were photographed by the researcher. After the film was processed, the photographs were arranged in sequence in the form of story-boards and further supported the written documentation of the observation-participation-reflections of the researcher. Copies of the photographs were provided to each of the women for their participation in the study. According to Leininger (1985), audiovisual media can provide an invaluable way to document and study health care and nursing phenomena. The use of this medium remains undervalued in research but is becoming more and more popular as a means to know and learn about human behavior and lifeways of various cultures.

Many purposes for the use of audiovisual media have been identified by Leininger (1985). First, audiovisual media can be used to document detailed information about specific phenomena. Its use to document the sequence of events and highly specific practices during the women's birth experiences was extremely important information that supplemented the researcher's field notes. Second, audiovisual media "may be used to analyze health and caring behaviors in a variety of human contexts and with reference to space, time, and interactional factors" (p. 332). This was clearly evident in each of the birth

experiences as many individuals responded to interacted with the women during crucial moments when note taking was not feasible.

Another purpose is that audiovisual media and provide important information for comparative studies about spontaneous or recurrent actions. During each of the birth experiences, similarities and differences were discovered, which were substantiated by the photographic evidence. Fourth, this method is valuable in order to identify and plan for "historical, cultural, social, and environmental changes" (p. 333). Individuals tend to believe in their own cultural system with its own beliefs and practices. Because birth is a universal life event, variabilities that are discovered in terms of cultural care meanings and practices may offer critical review of own beliefs and challenge health care professionals to evaluate and bring about change. Audiovisual media can also be used "to document and analyze human expressions, feelings, symbols, icons, and rituals in nursing" (p. 333). This was most evident in the visual presentation of the various human emotions expressed by key and general informants.

Another use for audiovisual media is as evidence for an archival data bank to store raw research data. Full explanations were provided to the key informants about the use of the photographic essay for educational and research purposes only. The key informants were all given the opportunity to examine and select those photographs that they did not want used for future presentations by the researcher. And finally, the seventh use for audiovisual media is that it can be used "to document and study teaching, consultation,

and clinical field work from a research perspective" (p. 334). The clinical interactions of the generic and professional care that was provided to the women were clearly evident in the photographic essay. Care practices were easily documented as well as the responses of the women to the interventions offered, i.e., back massage, medication administration, position changes, etc.

An old saying "the eyes believe themselves, the ears believe other people" supports the use of photography in research. If researchers attitudes toward the inconsistencies of sensory data were acknowledged, then the camera should be an acceptable means of recording visual information just as the tape recorder does for auditory information. The use of the photographic method for nursing research could be supported by knowing that nurses could learn more about themselves and their work, their visual senses could be sharpened, communication and education could be enhanced, caring practices more accurately evaluated, new insights and understandings could be generated, and finally, a therapeutic nature of interviewing using photographs could occur.

The advantages of using this method along with the ethnonursing research method were many. The research found that the photographs provided highly accurate documentation of not only the physical life event of birth, but the psychological and social dimensions as well. Complex insights into human expressions were revealed in recurrent patterning and interactional care practices. The reality of the context and its influence on the birth experiences became evident along with the sequence of actions that became apparent when analyzing the photographs.

Perhaps the greatest advantage of using this method was to document the birth experiences in a holistic, humanistic way with the emic perspectives clearly evident in the human expressions and naturalistic responses that were captured by the photographs. The most significant of the photographs that best represented the findings are presented in Chapter 4, Part 3, under the discussion relative to the themes. This visual expression offered an invaluable means by which care meanings and practices can be discovered and studied in nursing research, certainly for transcultural nursing research.

Research Design

The goal with the ethnonursing method was to discover the professional and generic care meanings and practices of Finnish women in birth. Emic knowledge is considered central to discovery and would serve as a baseline from which comparisons with women of other cultures, transcultural nursing knowledge where transferable, would be made. The discovery of emic knowledge was accomplished by proceeding with the following phases (Leininger, 1991). Phase one was to identify a domain of inquiry, area, or phenomenon to be studied and its potential significance to nursing. The domain of inquiry for this study has been identified as the generic and professional care meanings and practices of Finnish women in birth and will serve to advance perinatal and transcultural nursing knowledge and practice.

Phase two was to explore the available literature on the domain of inquiry. As summarized previously, the literature regarding human care, care of women in birth, and transcultural caring practices of women in birth was investigated

including literature from anthropology and the Finnish culture. Phase three involved preparing the research enabler guides, plans, and approvals. Such materials as photographic equipment, field notebooks, tape recorders, and transcribers, etc. were assembled prior to entry into the country. Several preparatory activities that were considered vital to the success of the study included: initiating the first contact, exploring the community attitudes, setting the living and working arrangements, and establishing trust, rapport, and reciprocity (Evaneshko, 1985).

In conducting this ethnonursing research, entry into the country of Finland was facilitated with the use of Leininger's Stranger to Friend Enabler Guide (Leininger, 1985). By moving beyond the protective facades of the "front stage" as described by Leininger, to the "back stage" where the truth in the real world prevails (p. 49), the researcher can become a trusted friend. The research is greatly facilitated when fear and distrust are replaced by trust, acceptance, and respect. The researcher initiated the first contact with the assistance of Finnish family members living in Espoo, a suburb of Helsinki, Finland. Once inquiry was made with the Director of Nursing at Central Women's Hospital, University of Helsinki, a follow-up letter including the researcher's resume and research proposal were sent. Permission was granted to conduct the research at Central Women's Hospital, University of Helsinki by the ethical board of the hospital.

According to Evaneshko (1985) the researcher should become aware of cultural attitudes within the community, i.e., suspicion, extreme shyness, or apathy which may reflect history with inexperienced researchers or from being

"overstudied". She further explains that a supportive attitude will result if the purpose of the study makes sense, the benefits are explained, participation in planning and implementation is encouraged, previous researchers have left a good impression, and pride in the community's cultural heritage is maintained.

In terms of living and working arrangements, the researcher should consider whether to live with the people or outside the community, that a central location and a match with the type of study are important. In establishing the identity or role, the researcher may be constrained by the social role or position to which the people assign, i.e., Indian-lover, rich tourist, etc. And, according to Evaneshko, a sense of trust, rapport, and reciprocity can be developed if the researcher adheres to and respects the local rules of conduct, is careful not to contradict beliefs, and includes the community in planning and implementation as much as possible. Being a friend and a willing learner will only enhance the ultimate success of the study (Evaneshko, 1985).

After permission was granted to conduct the research, the researcher received a letter from the Director of Nursing stating, "I have the great pleasure to invite you to do your interesting field research in our hospital" (personal correspondence, 1995). The cultural attitude identified by the researcher was one of enthusiasm and openness for conducting nursing research.

It was later discovered that this research was the first to be conducted at this facility by a nurse researcher and transcultural nurse. It also became evident throughout the investigation that Finnish people are proud of their heritage and are willing to share their cultural lifeways in order to benefit

others. Their sense of duty and obligation to accommodate the researcher was brought to light by the offering of an office and sleeping accommodations at the hospital at no charge or cost. The use of Leininger's Stranger to Trusted Friend Enabler Guide (see appendix G), allowed the researcher to move from a distrusted stranger to trusted friend in order to obtain authentic, credible, and dependable data that could be confirmed. A sense of trust and rapport were readily established when the Director of Nursing met to discuss the logistics of seeking key informants for the study and to plan meetings with various general informants for the purpose of learning about the Finnish health care system. Mutual respect for each other was clearly evident and necessary for the success of the study.

Research Context

Finland's health policy has evolved from the Health for All by 2000 program of the World Health Organization. The objectives of the policy are "to improve both the standard and distribution of health care. The former seeks to reduce premature deaths, and to enable people to live a longer and fuller life. The latter seeks to eradicate disparities in health between different socio-economic groups" (Ministry of Social Affairs and Health, 1996, p. 5). In order to achieve this goal, Finland's health policy seeks to promote health, prevent illness, and refine and expand the health service network. According to both Finnish and international evaluations, the Finnish health policy has had the desired results as evidenced by the infant mortality rate of 4.7 per thousand live births in 1994 which continues to be among the lowest in the world (Ministry of Social Affairs

and Health, 1996).

According to the Specialized Hospital Act, which came into effect on January 1, 1991, "it is the responsibility of the local authorities to provide necessary specialized hospital care for its inhabitants" (Helsinki University Central Hospital: Excellence in Action, 1992, p. 3). Because Finland has numerous municipalities with small populations, a collaborative effort has become necessary in order to organize hospital care and reduce costs. For the purpose of providing specialized hospital care, the country is divided in 21 hospital districts each one having its own central hospital. These hospitals are operated by the local authorities in the region (Ministry of Social Affairs and Health, 1996). The public coverage of health care costs is about 80%. Patient fees cover only 7% of expenses, the rest is paid by the local authorities and the government (HUCH, 1992).

Helsinki University Central Hospital (HUCH) is an acute-care hospital which has the most advanced specialized care for its health care district. The hospital also has certain nationwide responsibilities in providing treatment of rare diseases or demand specialized skills or equipment. In Finland, the treatment of cleft lips and palates, organ transplantations, open heart surgery on infants, and the poison information center are services provided exclusively by HUCH. The hospital is used by the university faculty for educational and research purposes; it organizes graduate and postgraduate education and engages in research in all medical specialties. Beyond medical student and physician training, HUCH provides clinical opportunities for many future health care

professionals.

The Women's Hospital (part of HUCH) is responsible for prenatal diagnostics, treatment of severe pregnancy disorders, gynecological cancers, infertility management, pubertal, and climacteric disorders. About 5,500 infants are delivered annually at the Women's Hospital. Perinatal mortality is 1.5% and about 19% of all infants are delivered by Cesarean. "Due to the efficiently organized prenatal care and the well-equipped maternity hospitals, Finnish mothers stand the best chance in the world of giving birth to a health baby" (p. 22).

Selection of Informants

To continue with the ethnonursing research process, identifying the people to be studied, involves purposeful selection of key and general informants. According to Evaneshko (1985), ethnodemographic characteristics should be considered such as age and sex, i.e., the young may talk but lack the inside knowledge, the old may have the inside knowledge but not wish to talk; females may only know about subjects concerning women, males may only know about subjects concerning men, etc. Informants may only tell the researcher what he/she wants to hear; informants may deceive because of being too embarrassed to admit ignorance.

Research approvals for this study were obtained from Helsinki University Central Hospital Ethical Board, from the researcher's employer, the Medical College of Ohio's Institutional Review Board, and from the researcher's university, the Wayne State University's Human Investigation Committee of the

Behavioral Institutional Review Board. Confidentiality was maintained by the researcher having sole control and management of the data, except for research mentor and dissertation committee chair Dr. Madeleine Leininger. Although permission was obtained from each of the key informants to use their first names, the researcher planned to use their first names only as a demonstration of language context. Written permission was also obtained to use the photographs for educational and research purposes only. Copies of all the photographs taken for each of the birth experiences were sent to all of the women as a benefit for their participation in the study. All tape recordings and field notes will be destroyed after completion of the study.

With the ethnonursing method, key informants are central to obtain the in-depth, emic, qualitative knowledge of the domain of inquiry. Ethnomethodologists want informants who "represent the community by virtue of their roles, status, age, sex, and experiences" (Leininger, 1985, p. 47). Key informants, ten Finnish women, were purposively selected as they entered into the hospital because they were held to be most knowledgeable about the generic and professional care meanings and practices as they experienced them. According to Leininger (1991), key informants are "held to reflect the norms, values, beliefs, and general lifeways of the culture, and usually are interested in and willing to participate in the study" (p. 110). This was confirmed by the fact that the first ten key informants that were asked by the researcher, agreed to participate without hesitation. They were the major source for gaining an understanding of the care meanings and practices, to

gain their emic perspective.

After approvals were obtained from each of the three institutions to conduct this study, flight arrangements brought the researcher to Helsinki within two days. The researcher had planned to live during the data gathering phase with family both in southern and northern Finland. After arrival in Helsinki, the researcher met with the Women's Hospital's Director of Nursing, Helsinki University Central Hospital for the purpose of discussing the selection of informants. The Director provided the researcher with an office and sleeping room which was most helpful to make extensive, continued, and indepth participation-observation-reflections of the experiences in birth.

The selection criteria for the women as key informants were:

1. identified themselves to be of Finnish heritage (born and lived in Finland for most of their lives),

2. were pregnant in their last trimester,

3. had an expected date of delivery within the time frame of the research,

4. planned for the birth at the research study site, and

5. voluntarily consented to participate in the study.

Professional nurses assisted in the prenatal clinic, located at the research site, each morning for the purpose of identifying potential key informants. With the informant meeting the selection criteria, the researcher introduced herself to the informant, reviewed the research purpose and benefits, then gave the informant the consent form to the read and sign if she chose to do so. The informant and significant other accompanying her spent time alone to discuss

any thoughts and/or concerns. Each of the key informants agreed to participate in the study and signed the consent form in the presence of the researcher. A copy was given to the key informant and the original consent form was retained by the researcher for her files (see Appendix B).

General informants were identified as the generic caregivers, i.e., the significant individuals who accompanied the women in their birth experiences from July 16,1995 to August 15, 1995, and the professional caregivers, i.e., the ten nurses that provided direct care to the women. According to Leininger (1991a), general informants are those who have knowledge with regard to the domain of inquiry and their views can be used to reflect on how similar or different their ideas are about the care meanings and practices from the key informants. General informants are "usually not as fully knowledgeable about the domain of inquiry, but do have general ideas about the domain, and are willing to share their ideas" (Leininger, 1991, p. 110). This information assisted in identifying the diversities and universalities that existed in the care meanings and practices of Finnish women in birth.

The selection criteria for general informants were:

1. generic, non-professional individual/s identified to provide direct care to key informants during their birth experiences,

2. professional nurse/s identified who provide direct care to key informants during their birth experiences, and

3. voluntarily consented to participate in the study.

The ten key informants with their generic care providers and professional

care providers during the birth experiences met the criteria for this study. All key informants identified themselves to be of Finnish heritage, were pregnant, expected to deliver within the established time frame at the research site, and voluntarily consented to participate in the study. All of the key informants were able to speak English. The ages of the key informants ranged from age 27 to 38 with a mean age of 32.2 years. All of the key informants had completed nine years of comprehensive school and then received either vocational or professional education to prepare them for future careers. Their vocational careers varied from restaurant management to bookkeeping to banking or working as a travel agent. Of the professional careers, three of the key informants were teachers, one of which was working on a post master's education. One key informant was a mechanical engineer, one was a dentist, one worked for the Finnish Ministry to the United Nations in Geneva, Switzerland.

Of the ten key informants, three were primiparas, seven were multiparas; all were married. The ten key informants had formalized prenatal care provided by nurses that involved monthly, biweekly, and then weekly visits to a prenatal clinic to be attended to either by a nurse midwife or obstetrician. All of the key informants had participated in prenatal education programs either with the current or previous pregnancies. These classes taught by nurses were held at the maternity clinics, were 3-4 weeks in length (one evening per week) and covered such topics as: anatomy and physiology of pregnancy, common discomforts during pregnancy, breathing and relaxation exercises for labor with

care measures, and infant care.

The ten key informants delivered in the birth rooms of the 16 bed labor and delivery unit. All of the key informants were accompanied by generic care providers with the exception of two women whose anticipated generic care providers were either working out of the country or unable to arrive at the hospital in time. The key informants were attended to during their birth experience by at least one professional care provider, sometimes two or three if nurses were changing shifts. Of the ten key informant's births, six girls and four boys were born. Only two of the ten women were able to share names that had been selected. It is customary in Finland to announce the name of the infant at the christening ceremony to be held within three months of the date of birth.

The key informants were selected and each of the women signed the informed consent forms, the researcher accompanied them to their birth rooms. At this time the observation-participation-reflection of the birth experiences began with recording field notes and photographing all observations from the point of admission to the birthing unit until the actual birth of the infant. All actions of the generic care providers and the professional care providers were recorded along with the resultant reactions and responses of the women. Observations were made and recorded with regard to timing and sequence of events, environmental contexts, medical technologies, specific comfort measures employed, etc. Personal reflections were also included in the documentation of data. By actively observing and participating in each of the

birth experiences, with the use of field notes, photographs, and reflection to collect information, the indepth data necessary for analysis was obtained.

Following each of the key informants' birth experiences, the researcher conducted an interview with all of the key informants in order to confirm the handwritten and recorded participation-observation-reflections. The interviews were held as important to gain insight into the informants' emic and etic perspectives with regard to generic and professional care meanings and practices. The interviews were held separately and on the day following their birth experiences. The interviews were held in the informants' postpartal unit hospital rooms with a curtain pulled around the hospital bed prior to the interview in order to maintain privacy. A tape recorder was used to record the verbatim statements of the key informant and the researcher. The key informants were accompanied by their newborn infants who at times interrupted the interview in order to have their needs met. The interviews lasted 2 to 2 1/2 hours in length depending on the informants' fatigue levels and/or the infants' demands. The interview data were kept in a locked file drawer in the researcher's office to maintain confidentiality.

Analysis of Data

This final step of the ethnonursing research process, the analysis and writing of the research findings occurred after leaving the field site and the country of Finland. Using Leininger's Phases of Ethnonursing Data Analysis Guide (Leininger, 1991a) (see Appendix H), the researcher identified themes derived from the emic and etic data of the generic and professional care

meanings and practices for the Finnish women in birth. The four phases of data analysis were as follows: 1) collecting, describing, and documenting the raw data; 2) identifying and categorizing descriptor and components; 3) analyzing pattern and contextual meanings; and 4) abstracting major themes, findings, theoretical formulations, and recommendations. These phases helped the researcher to systematically analyze the large amount of field data.

In the first phase, computer data analysis enabled the researcher to maintain continuous data processing with field notes from the participation-observation of the birth experiences and the tape recordings from the interviews following the birth experiences. The computer software, the Leininger, Templin, Thompson (LTT) Ethnoscript Qualitative program, allowed the researcher to explicate, through active analysis and reflection, the inductively identified patterns or themes. The LTT software is copyrighted by Wayne State University, Detroit, Michigan and was used with the Data Base III system. The coding system is based on Leininger's theory of Culture Care and has been tested by Wayne State University masters and doctoral students for their research and dissertations.

Each of the key informants were assigned two numbers. The first number was the number assigned to the informant, one through ten, in chronological order of their birth experiences. The second number was either a one or two, identifying the participation-observation field notes from the actual birth experience as one and the interview tape recordings as two. After the data from the field notes was entered into the LTT software sentence by sentence,

the photographs were reviewed for additional data. Following this process, the taped recorded interviews were then transcribed. The researcher utilized an electronic transcriber for this purpose. The tapes were then replayed on a stereo in order to check for accuracy and completeness of the verbatim. The entries were then coded. The codes were comprised of four numbers, each relating to a specific category from Culture Care theory. Some modifications in the coding system were made in order to enter this data and facilitate analysis of the evolving patterns or themes. Categories included general cultural domains such as worldview, environmental context, language, ethnohistory, and social structure domains such as technology, religion, kinship, cultural values, politics, economics, and education. Another category included the generic (folk) and professional care and caring. In this category the researcher added code numbers that related to comfort measures provided to the women by generic care providers and those provided by professional care providers. Other categories included features of health and social service institutions, life cycle and intergenerational patterns, and finally research features or methods (See Appendix I).

The following is representative of raw data coding:

Seija 62 "...He was a good help, it maybe looked like that he don't do anything but I thought it so that when he is near it's safer for me and when I can hold him it helps me to bear this pain"

The codes assigned to this verbatim and the meanings were:

20-belief or value held by the informant

23-emic belief or value demonstrating generic care

31-a comfort measure provided by generic care provider

39-an environmental feature within the birth room, i.e. her husband was present, holding her through the contractions

Sorting of the data was accomplished by selecting certain codes or words in order to detect patterns or themes. When the researcher entered the above codes, all statements relating to what the women valued in terms of generic care could be extracted. Therefore, by grouping raw data, descriptors could be identified, patterns analyzed, and themes abstracted. The discovery of these themes or commonalities contributes to in-depth understanding of culture care and enables nurses to provide culturally congruent care.

In the second phase of analysis, coding of both field notes and interview tape recordings along with the photographs continued. As emic or etic descriptor statements were identified, their meanings were studied for similarities or differences. Any recurrent components were further examined. For example, similarities were found among the key informants in statements that indicated as strong sense of nationalism and pride in their country. Example descriptive indicators were:

Key Informant: 1, 1	"We have a sense of duty"
Key Informant: 4, 2	"Finland, it is very important to me ... I never can go anyplace else"
Key Informant: 4, 2	"I love it, I believe in Finland, I believe in Finnish people, I want to be here in Finland"

The third phase of data analysis included the continued discovery of patterns and saturation of ideas that related to the domain of inquiry. Patterning with respect to meaning-in-context was further examined in order to establish credible findings. This phase also included the interpretation of findings so that major themes could be abstracted and presented as research findings. An example of this level of analysis became evident in the generic care patterns and ideas that the key informants revealed was valuable from their emic perspective. Such patterns as being near or being there, touching, stroking, whispering, and holding, all indicated a commonality of "physical presence" as an identified pattern. The context with which "physical presence" became apparent was examined to find that many key informants valued not only "generic physical presence" but "professional physical presence" as well.

The fourth phase of data analysis is the highest phase of synthesis and interpretation. Through this synthesis of thinking, interpreting findings, and creative formulation of ideas from the previous phases, "the researcher's task is to abstract and present major themes, research findings, recommendations and sometimes theoretical formulations" (Leininger, 1991a, p. 95).

An example of this phase of analysis was the following theme that was created from the patterns identified in the previous phases: Finnish women desire "professional care theme: educational support". The patterns of the professional nurses giving information regarding such medical technologies as electronic fetal monitoring, intravenous therapies, pain relief measures, and teaching about various options or choices for labor and birth positions, etc.

revealed interpretations that confirmed the formulation of that particular theme of educational support. In order to present this as a finding, the researcher confirmed this theme with each of the key informants by sharing these patterns with them and using the qualitative criteria. Certain recommendations that evolve from this finding were to share with the nurses how this was a highly valued feature of professional care by the key informants and to reinforce their educational support methods.

Criteria to Substantiate Findings

In qualitative research, the goal is to gain knowledge and understanding of the true nature, essence, meanings, attributes, and characteristics of a particular phenomenon under study. Knowing and understanding the phenomenon is the goal (Leininger, 1991b). Qualitative findings rest upon knowing and understanding the phenomenon as fully as possible rather than on measuring results. Qualitative research focuses on specific criteria to document recurrent, accurate, and consistent or inconsistent features, as patterns, themes, values, world views, experiences, and other phenomena confirmed in similar or different contexts (Leininger, 1991b).

Because ethnonursing has as its goal description and understanding, an inductive view of science, the criteria to evaluate the findings should not be the same criteria as used for quantitative research. Moreover, the two paradigms have different purposes and goals and should not be used together. The following criteria have been developed and used by Leininger (1990) and Lincoln & Guba (1985) in order to evaluate qualitative studies within the

naturalistic paradigm. They are credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability.

Credibility refers to the "truth" value, the believability of the findings and entails prolonged engagement with the informants. Confirmability refers to verifying the data directly with the people, the direct evidence which is validated by repeated accounts with the informants. Meaning-in-context refers to the data that are understandable within the situation, the setting, the experience, etc. Recurrent patterning refers to the experiences or events that occur consistently in patterns or sequences over time. Saturation is evidence that all that is known or understood about a phenomenon is collected. And finally, transferability refers to the findings that have similar meanings and uses in similar conditions or circumstances (Leininger, 1990).

The criteria as described were used in substantiating the findings of this qualitative study of Finnish women in birth. In terms of credibility, collecting data in a role as co-participant and observer with the key and general informants during their birth experiences, certainly lent credibility to the reality of the experience and the findings. Credible findings are produced, through prolonged engagement in the field, persistent observation, use of two or more methods for getting information, and peer review of the data and analysis (Leininger, 1990a, 1991; Lincoln and Guba, 1985, p. 301-316).

Before initiating this research, the researcher and her family had the opportunity to host through the American Field Service, a foreign exchange program whose goal is world peace and understanding, two different students,

each from different areas of Finland, each for a full academic year. This experience afforded many opportunities to learn about the Finnish culture and language. The extended family members of these students each visited the researcher in the United States so that relationships between host family and Finnish families were maintained. The researcher also traveled to Finland and lived with the first student's family during which time she attended his comprehensive school graduation, attended a double wedding, and participated as godmother in a Finnish christening ceremony. These experiences gave the researcher opportunity to live within the culture and to learn Finnish cultural lifeways related to values, beliefs, and life practices in Finland. These opportunities also assisted the researcher to gain an indepth understanding of the culture and to set aside preconceived ideas that might have led to inaccurate or biased interpretation of the later emic data that was collected from the key and general informants.

As discussed earlier, to further assure credibility and skill with the theory and the research methods, the researcher conducted a mini-ethnonursing field study in the United States using similar research questions, methods, and Culture Care theory with Euro-American women in birth (Lamp, 1994). The mini-field research, with transcultural nursing mentorship helped the researcher to participate and observe in actual birth experiences while collecting data as field notes and video taping. The experience resulted in valuable information in using the ethnonursing research method in a large metropolitan hospital, but in a different in culture. Many advantages of using

the ethnonursing and audiovisual methods in order to document the rich and indepth emic cultural perspectives of key informants were found.

With this study in Finland, prolonged observation and participation in the women's birth experiences met the credibility criterion of the care meanings and practices as their truths became evident in the interviews with the key informants following their birth experiences. After returning to the United States, further confirmation of the findings were solicited by means of using birth stories written by key informants. Key informants were asked to write about their birth experiences within one year of the birth using enabler guidelines developed by the researcher. If the information provided by the key informants was found to confirm the findings, it was considered credible. Information that did not confirm the findings was used for further investigation as a diversity factor. However, only two of the ten key informants responded with their birth stories and no discrepancies in the data were found. Credibility was largely established by rechecking the key informants' responses to inquiries on the domain of inquiry.

Confirmability refers to "establishing verifiable direct evidence with the people" (Leininger, 1990, p. 43). Repeated accounts from key and general informants firmly substantiated what was observed and experienced with regard to the generic and professional care meanings and practices. Actual observations were shared with the key informants, photographs were copied and sent to the key informants, interviews were transcribed by the researcher so that explication of themes could be verified. By listening repeatedly to the

tape recorded interviews on various media, by rereading the field notes, and by reexamination of the photographs that captured the essence of the care meanings and practices of each of the birth experiences, the researcher became immersed in the data, reflecting on the data and informant responses. Complete involvement and dwelling with the data over time was important to establish credibility and confirmability. The findings were shared between the researcher and key and general informants during follow-up interviews and sharing of recorded and photographic data, until mutual agreement of identified themes was reached.

In terms of meaning-in-context, the relevance or meaning of the findings were evident and understood within the context of the birth experience, the hospital setting, and the people present. Certain generic care practices such as touch and massage were especially relevant to the women experiencing the pain of labor. Identified professional care practices such as the teaching of breathing and relaxation exercises as a way for the women to cope with the pain of labor hold relevance especially in birth. These care practices were specifically meaningful in the birth experiences observed in the hospital setting despite the additional context of medical technology. The technological methods for coping with the pain of labor, i.e., epidural, nitrous oxide inhalants, etc. were available and often employed; however, they are only available in the hospital context. Birth experienced in another setting, another context, may not use this type of pain management. Other generic and/or professional care practices may become more relevant in another context. As witnessed by the

researcher, acupressure and water, along with the more traditional methods of pain management such as breathing and relaxation techniques, were used in a small, rural hospital setting. The context was important to establish the meaning of the technologies and informal care practices.

Another criterion for evaluation was recurrent patterning. The researcher found that the generic and professional care meanings and practices became evident with recurring patterns over time; therefore, consistency in these features occurred within each experience. This criterion was reinforced by participating and observing in each of the birth experiences and focusing on the patterns that were expressed by the women. The sequence of events in terms of the birth experience itself and the generic and professional care practices were studied for patterned meanings by looking for repetition and similarities in the care provided. Despite the many individual differences in the births experienced by the women, many of the care features showed identifiable patterns over time.

In early labor, the professional care practices often included orientation to the birth room or setting, discussing the available options for positioning and comfort management, teaching of breathing and relaxation exercises, etc. As labor progressed, the professional care practices became more focused on pain management and preparing for the birth. As birth became imminent, an additional professional care provider attended the birth to assist. The care practices then were directed toward a safe birth, attending to the immediate needs of the infant and mother, assuring close contact between mother and

child. These observations occurred in this designated sequence in each of the birth experiences and supported the consistency that is evident in recurrent patterning.

It was desirable to take in all that could be known about the care meanings and practices of Finnish women in birth. This became evident as the data appeared redundant in the course of analysis. This supported the criterion of saturation. Saturation refers to "the taking in of occurrences or meaning in a very full, comprehensive, and exhaustible way" (Leininger, 1991a, p.114). When the researcher found all that could be discovered and understood, the care meanings and practices for Finnish women in birth were established and saturation was achieved. Throughout the research process it was becoming increasingly evident that the data were approaching redundancy. The care meanings that were derived from the key informants such as physical and emotional presence by the generic care provider supported this criterion.

Transferability, as the last criterion to evaluate qualitative research, refers to whether the findings discovered had similar meanings in similar situations or contexts, i.e., the generic and professional care meanings and practices of one birth experience indicated similar significance in similar birth experiences. The themes identified were similar in each of the birth experiences; therefore, they hold significance for other women experiencing birth in a similar context. However, a different context for birth may reveal different findings. While it is not the goal of qualitative research to produce generalizations, there were similarities of findings evident within the similar contexts, very limited diversity

among the key informants with regard to care meanings and practices.

Congruent with the tenets of the qualitative paradigm, these criteria helped to obtain accurate values, indepth meanings, and full account of cultural lifeways under investigation. Contributing to transcultural and other areas of nursing using humanistic inquiry, this research has been important to advance nursing knowledge and practice. The need exists to discover and understand women of diverse cultures throughout the world, to explore their experiences of birth, to know what care meanings and practices offer them the greatest sense of well being. An understanding of Finnish women, their birth experiences, and the generic and professional care meanings and practices would assist nurses in planning for more culturally congruent and specific care in the future as our world becomes more culturally evident.

CHAPTER IV

Analysis of Data

In this chapter, the data as discovered from key and general informants will be presented in three parts. Using the Leininger Phases of Ethnonursing Analysis for Qualitative Data (see Appendix H), Part One will include collected and interpreted data from the observation-participation-reflections (Phase 1 of the research enabler) of each of the key informants' birth experiences.

Part Two includes data from each of the key informants' interviews. Emic data include the words, expressions, worldview, and experiences by the women. Actual verbatim statements in the language is presented in keeping with emic data and to help the reader enter the world of the key informants. The recordings were expressed and written in English. The key informants spoke English as a second language. Finland is a bilingual country of Finnish and Swedish languages. English was the chosen language to study and speak as a second language by the key informants. The ten key informants spoke English fluently; however, some informants were shy or hesitant about their ability to speak English, explaining that English grammar, not conversational English, was the focus in their educational programs.

Part Three presents a discussion of the generic and professional care meanings and practices from the emic data. Using the Leininger Phases of Ethnonursing Analysis for Qualitative Data, the patterns (Phase 3) and themes (Phase 4) derived from the analysis are discussed with reference to Culture Care theory and supported with illustrations determined to represent the

themes. This discussion will include how the worldview, social structure, ethnohistory, language, and environmental context dimensions influenced generic and professional care of Finnish women in birth. Cultural diversities and universalities from the analysis that substantiate the theory of Culture Care with the domain of inquiry will be identified.

Part 1

Participant-Observation-Reflections of Birth Stories

The Birth Story of Pirkko

Pirkko and her husband were seated in a large waiting room. She was dressed in a long sleeved, knit gown that buttoned up the front which was provided for her by the hospital along with white socks and sandals. There were many couches and chairs for clients and families in early labor. There was a television playing in the corner; a table with children's games, books, and magazines was placed near the center of the room. After introductions, the research was explained, and consent obtained. Pirkko then explained that she was having mild contractions, that she had been scheduled for gel "to start the contractions coming" but "I am glad that I started contractions anyway ... it is a natural birth day".

She and her husband were then shown to a birth room by a nurse. The room was bright with one wall having large windows over which hung a flowered valance that allowed the sun to shine in. The labor bed was centered in the middle of the room. (The Director of Nursing had explained that the 16 birth rooms had recently been remodeled from surgical suites; hence, the bed's

location in the center with all available electrical and surgical hookups hanging from the ceiling.)

Pirkko climbed onto the bed. The nurse oriented her to the room by explaining the signal cord, the telephone, the bathroom, the lights, etc. She then applied the external electric fetal monitor to Pirkko's abdomen. Pirkko's husband watched the monitor intently as he held her hand. He asked the nurse questions about the monitor. Pirkko explained that this was a "special baby; our only one".

As the nurse was writing at the desk, Pirkko asked her if her pelvis was too narrow, "Will I need my pelvis x-rated (x-rayed)?" The nurse gestured that she didn't know. Pirkko then stated, "I'm so glad that I started contractions; this is exciting". She explained that she had awakened with fetal movement at 0230 and the contractions started at 0430; that her due date was July 6 and that she was 41 weeks plus 6 days; that the estimated fetal weight is 3.8 kilograms, estimated length 35.5 centimeters. "Both my doctor and I made the decision to try and labor first; baby is not attached (engaged)".

Her husband described the prenatal classes that they had taken together. They had also read books in order to prepare for infant care and parenting. He continued to watch the electronic fetal monitor, noticing the fetal movement and stated "Wants to get out". Pirkko explained that she had had her chromosomes checked. "I am 37 years old so checked for Downs Syndrome and spinal defects. It's a boy" (Her husband then explained that there is no gender distinction in the Finnish language so it is not a problem to discuss the

infant's gender prior to the birth.)

Pirkko was assisted to the bathroom by her husband. The physician entered to review her records with the nurse. Pirkko returned to her bed with her husband's assistance, then he retreated to the corner, folded his hands, awaiting to see what the physician will say or do. The physician performed a sterile vaginal exam and found that Pirkko's cervix had shortened and was beginning to dilate; therefore, no gel was necessary to start contractions. The nurse gave Pirkko a pad and panties to wear and helped her up to a rocking chair and then offered her some juice and yogurt.

Pirkko's husband discussed his perspective on the differences between Finnish and American people. He stated, "We are shy; we are law abiding; we have a sense of duty; we were the only country to pay off the war debt". Also discussed was the American's fear of litigation regarding health care. He continued by saying, "There is not much litigation; the money is limited for litigation and it correlates with the amount of loss".

Another nurse (change of shift) entered to initiate intravenous oxytocin which will stimulate Pirkko's contractions. Once Pirkko returned to bed, the nurse performed a sterile vaginal exam and then adjusted the fetal monitor belts. Pirkko's husband massaged her arms and helped her turn to her side. The nurse palpated the contractions with her hand on the uterine fundus. The physician entered again for a sterile vaginal exam and since the infant was still rather high, delayed the decision to rupture the membranes. The nurse turned up the oxytocin and asked the physician for a medication order. The physician

answered (as interpreted to the researcher by the nurse) that he didn't think it was necessary at this time. The nurse stated that she had had 28 years of experience and knew the benefit of medication to be used at this time.

As the nurse retrieved the medication, Pirkko's husband helped her to the bathroom and then back to a birthing stool. The nurse returned with the medication and administered it intramuscularly in her hip. Pirkko returned to bed, inserted ear plugs that she had brought, and placed an eye mask on the table next to her bed. Her husband sat close to her rubbing and patting her legs. He began to breathe with her while massaging her legs. Occasionally he kissed her through contractions. Later, Pirkko began to vomit; her husband held the pan for her and then emptied and rinsed it in the bathroom. Pirkko stated, "it feel good to have him (husband) here". He answered, "I want to be here".

For a period of time Pirkko appeared to sleep. Her husband read the newspaper. He again assisted her to the bathroom. The nurse straightened the room, placed clean pads on the bed. She then told Pirkko's husband to stay with Pirkko in the bathroom for awhile so that she continued to have contractions while sitting on the toilet. Pirkko returned to bed and the nurse instructed her to sit on her knees facing the back of the bed so that continued contractions in a semi-squatting position.

After another vaginal exam the nurse discussed the possibility of an epidural with both of them. The epidural cart was brought in by the nurse. The membranes were then ruptured by the physician using half of an Alice clamp

(as opposed to the disposable plastic amnihooks in the U.S.). The internal fetal monitor was applied. Pirkko's husband remained at her side, standing with his hands folded. The anesthesiologist entered to administer the epidural. No disposables were used for the anesthesia. Pirkko became more comfortable after a period of time and continued to rest.

Pirkko's husband discussed with the researcher the Finnish sauna. Two types of saunas are common in Finland. The electric sauna with a stove that heats the stones is convenient but the smoke sauna is "softer, plus smells good from the woodsmoke". They both continued to use the sauna throughout the pregnancy. Pirkko then complained of rectal pressure and the nurse began to prepare the room for the birth. The nurse assisted Pirkko up to a portable commode next to her bed. The midwife then allowed the water to run so that Pirkko would empty her bladder and bowel more easily.

She returned to bed for a vaginal exam which revealed that she was now 8 centimeters. The nurse noticed fetal distress on the electronic fetal monitor strip. She gave oxygen by facial mask to Pirkko. The physician entered; another nurse (change of shift) continued to assess the fetal heart rate. A vaginal exam revealed that Pirkko was almost 10 centimeters so the nurse instructed her in how to bear down and push. After Pirkko pushed with a few contractions, the nurse assisted her to turn to her side to continue pushing. She then returned to her back, continued to bear down with her head elevated by her husband. The fetal distress continued with each contraction; Pirkko continued to take in oxygen.

The physician performed a vaginal exam and then decided to facilitate the birth by using a vacuum suction to assist in the bearing down efforts. An episiotomy was performed. The birth of a boy immediately followed with spontaneous respirations. He was dried an handed to Pirkko. Her husband stood close touching the infant as he laid on Pirkko's chest underneath her gown. He leaned down and kissed his son. He then carefully picked up his son and took him over to the preheated crib. Another nurse wrapped him in warm blankets and returned him to Pirkko's husband. Both Pirkko and her husband were smiling.

Reflections: This birth experience appeared to progress quite normally according to my experience. It is apparent the Pirkko highly values this baby since it is their "only one"; however, did comment afterwards that she may want more. She claimed that "natural is best" which would lead me to believe that she values birth without intervention. She stated that she also valued the health care system, the nurses, and the technology that was available. This appears to be in conflict with minimal intervention but fits with the apparent respect for authority. She seemed to appreciate the open communication with her husband and his presence during her birth experience. She stressed that family is very important in their lives.

<u>The Birth Story of Carita</u>

After obtaining consent, I accompanied Carita from the clinic to the birth room. She was dressed in a long-sleeved knit gown with button front. She also had on the typical, hospital provided white socks and sandals. She explained

the her membranes had ruptured spontaneously at home. She had been vaginally examined in the clinic and was found to only be dilated to 1 centimeter. She had not started any contractions as of yet. The nurse oriented her to her room, then darkened the room except for a skylight. She spoke softly as she explained to Carita the signal cord to call the nurse, the telephone system, the electronic fetal monitor, etc.

Carita explained that her husband was in Estonia at the present time. He is a construction engineer for commercial buildings and was building a new Stockman's department store in Tallinn, the capital of Estonia. Carita then shared that she herself was a dentist in private practice. She held a private practice so that she could be "home with the children". She is a gravida 5, para 4, having 3 boys and 1 girl at home ranging in age 4 to 10 years.

Carita attempted to call home but no one answered. She explained that no one would be with her during her birth. The only complication that she experienced with this pregnancy was morning sickness for 2 weeks. Another nurse (change of shift) entered, introduced herself, examined Carita by performing Leopold's maneuvers, and then proceeded to do the admission paperwork. Carita quietly answered the nurse's questions. The nurse brought her a light meal consisting of "meat soup", yogurt, milk, and juices. She got up from the bed and sat in a chair to eat. Still there were no contractions. An hour later there were still no contractions. Carita continued to rest quietly, reading magazines. The nurse entered an hour later and initiated intravenous oxytocin to induce labor contractions. Carita was assisted to a rocking chair by the

nurse; the electronic fetal monitor was applied.

Four hours after the induction was started, Carita's membranes appeared to rupture spontaneously again. Carita soon after complained of increased rectal pressure and was assisted by the nurse back to bed. The nurse gave her a cool cloth for her face; she then changed the pads on her bed. The nurse massaged her back to help her cope with the intense contractions. Carita was then offered nitrous oxide gas as a self-administered anesthesia for the pain. More amniotic fluid was expelled.

Carita then felt the urge to bear down. She was instructed to push by holding onto her socks. She pushed with the bed in a semi-reclined position. Another nurse entered to assist. A small birth pack was unwrapped at the foot of the bed. The cloth pack contained only a select number of instruments: a towel clip, a pair of scissors for a possible episiotomy, a pair of scissors to cut the umbilical cord, two hemostats, a string to tie off the umbilical cord, an injection of vitamin K for the infant, and a tin pan for the placenta.

The birth of a boy immediately followed. The infant was dried off and then placed on Carita's chest. As the placenta was delivered, the telephone rang; her children were calling. She talked to them while the placenta was delivered. The telephone continued to ring as her family members called her. She held the infant on her chest under her gown. Once the umbilical cord was cut, the infant was then wrapped and taken to the nursery for an initial assessment and evaluation. The infant was then bathed, dressed, wrapped, and then returned to Carita. She immediately began to breastfeed. She appeared quite happy

and confident.

Reflections: This birth experience progressed quickly and Carita coped with the intensity of the contractions with minimal assistance. She described the birth as "quite terrific" which would lead me to believe that she was pleased with her efforts. She appeared to value the presence of the nurse stating that the trust that she had with the nurse having her there through the total experience was very important to her. She claimed that the nurse's presence helped her through the pain, it was like having her family there, so beautiful, so calm. She spoke of her family with pride and because of her choosing to stay home with her children, she highly values family.

The Birth Story of Elisa

Elisa was in the examining room with the physician in the clinic. She emerged to find her husband and explained to him that she must go downstairs to ultrasound and x-ray in order to see if her pelvis was of adequate size. As Elisa was getting her diagnostic tests, Elisa's history was discussed with her husband. Elisa and her husband lived and worked in Geneva, Switzerland although they were from Finland. Elisa worked for the UN and her husband was an economist. They both decided that they would come home to Finland to have their infant, their first, because her family was there and because it was much cheaper.

It was decided that Elisa would be admitted for PG gel that would induce labor. Elisa changed into the hospital provided, long-sleeved, button gown, socks, and sandals and was admitted to a softly lighted birthroom. As the

nurse was inserting the gel into the cervix by means of a vaginal exam, she explained to Elisa and her husband that this process may take many days for actual labor to begin. (It is my experience that if the cervix is not ripe or ready for labor that this is indeed true. I have been witness to increasing numbers of artificially induced labors that take two or sometimes three days if the cervix is not ready for labor.) The nurse then brought magazines to Elisa. She explained the electronic fetal monitor and its purpose to monitor the infant's response to labor. Elisa chose not to call her family until "things get going". She explained "there is much pressure because this is first grandchild on both sides" of their families.

Several hours later Elisa was reading a paperback book; she was having some "small contractions". It was decided to transfer her to the ward (postpartum unit) for reapplication of the PG gel and for "a good night's sleep." However, 3 1/2 hours later, Elisa remained in the birthroom because her membranes had ruptured. Her husband was reading a magazine at her bedside. Elisa expressed the need to get up; her husband assisted her to a rocking chair which was brought in by the nurse. Her husband massaged her shoulders while she rocked. The nurse then administered a medication to help Elisa sleep for the night. She returned to bed; the lights were dimmed.

The next morning Elisa was up in a chair eating breakfast. The nurse entered to initiate IV oxytocin to augment her contractions. A laboratory technician entered to draw blood. Elisa's husband stated that he had slept there overnight. Elisa stated, "I'm so disappointed in myself, I can't believe".

She placed the axillary thermometer under her arm as requested by the nurse doing her morning assessment. Elisa stated, "This is great; nothing is happening".

Her husband appeared to try and change the subject by discussing his impressions of the Finnish economy. He stated that taxes were based on a progressive incremental tax rate, i.e., the average salary being 10,000 Finmarks (FM) would mean a tax rate of 40%, greater than 10,000 FM would be 50%, greater than 20,000 would be a tax rate of 60%, etc. Because of this ceiling, many employers or business owners have holding companies. The tax money then is used by the government for medical and social welfare benefits and for state companies which in turn give money to the taxpayers. The biggest difference between Finland and the U.S. is that the U.S. fosters competition; whereas, Finland "protects its borders and its products". He continued by describing Finland's economy by discussing unemployment and how it peaked in 1992-93 at 20-22% but that it currently was 17%.

About midmorning, a physician entered for his morning rounds. He showed the x-rays to Elisa and her husband. Her husband asked many questions. After he left, Elisa shared with the researcher that her initial physician in Geneva, Switzerland had questioned her pelvic adequacy. The x-ray indicated that she should continue with labor to see if progress could be made. The nurse explained the electronic fetal monitor to Elisa's husband and showed him the use of a fetoscope. A half hour later, the contractions began to increase and Elisa wanted to return to bed. The IV oxytocin was adjusted by the nurse. She

offered Elisa nitrous oxide for the increasing discomfort but Elisa refused stating that she preferred concentrating and breathing on her own (her husband left to go home and clean up). The nurse assisted Elisa to the bathroom. Her husband returned and then with Elisa's permission, he called her parents.

After two hours Elisa summoned the nurse to assist her with the increasing pain. The nurse assisted her to the bathroom first and then back to bed. Elisa's husband then began to massage her back. He often commented on the fetal monitor printout and the height of the contractions. Elisa began to cry with the increased pain. The nurse performed a sterile vaginal exam to reveal that she was only dilated to one centimeter. She then explained to Elisa that she would have to wait for anything further for pain until she had progressed a little more. She did administer some pain medication. Elisa was crying and sobbing, "Surprise, surprise, the cervix is not open, oh my god".

An hour and a half later, Elisa began to use the nitrous oxide to help her with the pain. She exclaimed, "I can't take this any longer. Why don't they come?" The nurse entered to increase the IV fluid rate (possibly for epidural anesthesia). The physician entered to apply the internal electronic fetal monitor. Both the nurse and physician then left the room. The nurse soon returned to set up the equipment for an epidural. Elisa's husband helped her turn side to side, massaging her back. He stated, "I'm here to take care of you". Elisa responded, "It's like hell on earth". Fifteen minutes later a physician and nurse entered to both perform a vaginal exam. The physician then proceeded

to perform a paracervical (anesthetic agent is injected into cervix for local anesthetic effect). The nurse explained that an epidural would not be administered for another 30 minutes. The epidural was administered 45 minutes later. Elisa's husband assisted with positioning. Elisa became increasingly more comfortable.

For two hours Elisa rested. The nurse increased her IV oxytocin rate and in half an hour Elisa complained of increasing pain. Elisa's husband began to rub her back again. Elisa responded by saying, "keep doing that". Another nurse (change of shift) entered to perform a vaginal exam to reveal that Elisa was at 8 centimeters and said that the head was coming down. The epidural was redosed. The nurse reassured Elisa by holding and stroking her hand. Elisa slept.

To pass the time, Elisa's husband shared with the researcher that many Finnish families start having children before marriage. He stated that there were better tax benefits if the couple remained single and lived together. Therefore, many choose to marry after the children have been born. The social stigma of "out-of-wedlock" children doesn't seem to exist in Finland.

The nurse entered to again increase the IV oxytocin. She remained at Elisa's bedside, appearing to simply converse with her to pass the time. At midnight the nurse performed a straight catheterization to empty Elisa's bladder. A vaginal exam revealed that Elisa was now 10 centimeters and was instructed to bear down. The fetal heart rate dropped on two separate contractions. Looking concerned, Elisa's husband continued to massage her

back. Elisa complained of increased pressure. Elisa continued to push as instructed by the nurse. After pushing for 20 minutes, a physician performed a vaginal exam. She stated, it "feels a bit high", that "it needs to come down some more centimeters". Elisa complained of more discomfort. The nurse assisted her to push. Her husband continued to massage her legs and wipe her face with a cool cloth.

At 2:00 a.m. in the morning, with the nurse continuing to assist Elisa in bearing down, Elisa appeared to be weakening. She cried, "this whole thing is abnormal". Elisa's husband left the room for a break. At 2:30 a.m. the physician returned, performed a vaginal exam, and then decided to perform a Cesarean birth. Once she was prepared for surgery, Elisa was taken to the operating room on her bed. Her husband was instructed to change his clothes and follow them. At 3:27 a.m., their boy was delivered. A pediatrician was called in to attend to the infant in case there were any problems. Once the infant was stabilized, he was wrapped and handed to Elisa's husband.

Reflections: Elisa appeared to value the Finnish health care system as evidenced by the fact that she took a leave from her work in Geneva, Switzerland to return to Finland to have her baby. Elisa's birth experience was long and difficult. It appeared that the health care professionals were giving her every chance possible to deliver vaginally. The conservative efforts of the medical staff in delaying her Cesarean birth, however, lead Elisa to develop a lack of trust in their judgment. She appeared angry with her birth experience and very concerned for the health of her baby. She did claim that she valued

her husband's continual support with his touch and massage but stated that the nurses were gone most of the time, not attending to her needs.

The Birth Story of Linea

At 1:00 p.m. Linea was admitted to the birthroom. She had come to the clinic with some "spotting" and "postmaturity". She stated that this was her third, that she had a three and one year old at home with 12 and 6 hour labors respectively. As she used the telephone, she explained that her husband did not like hospitals and that her sister had previously attended her births. It was a bright sunny day; the room was brightly lighted with sunlight. The nurse began the admission process by performing Leopold's maneuvers, attaching the electronic fetal monitor belts, and instructing Linea about the monitor. Linea was then assisted up to a rocking chair. Linea adjusted the fetal monitor belts by herself for a better tracing on the printout, and then began rocking with the light contractions.

Another nurse returned (change of shift) and explained the fetal monitor tracing to Linea. She explained that Linea could receive her epidural when she reached 4 centimeters but not after 6 centimeters because her labor would proceed too quickly after that point. Linea's contractions progressed to a five minute frequency and she began to breathe with her contractions. The nurse assisted Linea back to bed, started the IV, performed a vaginal exam that revealed that she was 4-5 centimeters. She asked Linea questions related to her epidural history.

Linea began to cycle her legs on the bed indicating increasing discomfort;

she began to moan as she concentrated on her breathing. The nurse started to prepare for the birth by readying the infant's bassinet. She then gave some water to Linea and massaged her back. She prepared the bed with extra pads for the rupture of membranes and the internal fetal monitor. The internal fetal electrode was inserted by a physician rupturing the membranes at the same time. Linea was now 7-8 centimeters. The nurse instructed Linea to slow her breathing as she lowered the lights and readied the epidural cart.

The anesthetist entered and administered the epidural while Linea lie on her side. The nurse provided massage for her feet. She prepared for the birth by retrieving the birth pack, water, etc. The anesthetist checked Linea's blood pressure twice, talked with her. Linea began to smile and talked with the nurse and the anesthetist, appearing more comfortable.

Linea used the telephone to call her sister. The nurse conversed with Linea and after about 15 minutes, performed another vaginal exam to find that Linea was 9 centimeters. She instructed Linea to pant lightly with each contraction. Another 15 minutes passed and the nurse instructed Linea to push with contractions. Linea admitted that she didn't feel the urge to push. After waiting another 15 minutes, the nurse injected oxytocin into Linea's IV solution in order to increase the contractions. Linea continued to push gently while lying on her side. At 4:25 p.m. Linea delivered a girl in the occiput posterior position. The infant was placed on her mother's chest, inside her gown. Linea held her close, then tried to initiate breastfeeding. After a few attempts, the umbilical cord was cut and the infant was placed in the warmed bassinet. She was taken by

another nurse to the nursery for measurements and an initial assessment and evaluation. She was bathed, clothed, wrapped, and returned to Linea. Linea held her close.

Reflections: Linea's birth experience progressed quickly and without complications. She appreciated having the nurse present for support and admitted that she was more assertive in her requests for assistance than with her previous birth experiences. Linea appears to be an independent woman as evidenced by stating that she had her own career and doesn't want to work for her own family but have her "own work". She claims that she values being a mother but is her own person, ie., she has her "own development and own respect to foster, not simply children".

The Birth Story of Leena

At 10:30 a.m. Leena was admitted to the birthroom; she had already changed into her gown in the clinic. She climbed onto the bed so that the nurse could begin her initial assessment and examination. Her husband was with her and he assisted her onto the bed. The nurse performed Leopold's maneuvers and explained the electronic fetal monitor as she applied the external belts. The nurse then oriented both Leena and her husband to the room, the lighting, the music, the telephone, etc. Leena's husband sat next to her bed and observed the fetal monitor while Leena was having mild contractions. Both are from a small town near Helsinki; they are both mechanical engineers. They explained that they had taken classes for this infant, their first, that consisted of 3 or 4 classes on infant care and 2 classes which prepared them for labor. The

classes included a hospital tour, relaxation exercises, and a priest in order to learn about baptism.

Leena was assisted to a rocking chair by her husband who sat next to her. The nurse brought Leena a tray of juices and yogurt but Leena explained that she was lactose intolerant. She drank some of the juices. The nurse explained pain relief measures for Leena that included a discussion of nitrous oxide and epidural options. Leena's husband continued to sit beside Leena as they described that they felt that it was quite normal to have a researcher with them at a "university hospital" such as this was. They shared that they had been "warned" by the instructors of the childbirth classes about the potential of having students with them. They also explained that they chose this hospital because they "thought it was wise because of treatment; that their child would be transported here if a problem existed, so only natural".

After her light lunch, Leena's contractions started to appear more uncomfortable as evidenced by her breathing techniques. She was assisted back to bed by her husband "for a change". The room was darkened, the radio was playing softly. Her husband sat behind Leena and massaged her lower back during the contractions.

At 2:30 p.m. Leena's membranes were ruptured. The internal fetal monitor was applied and the nurse gave Leena some fresh water to drink. Leena complained of increasing back discomfort. Her husband continued to massage her lower back as directed by Leena for comfort. Another nurse (change of shift) appeared to again perform Leopold's maneuvers. Leena continued to

labor on her side while her husband massaged her back. The nurse encouraged Leena to get up to sit in a rocking chair. Her husband held up a gown for a cover. The nurse instructed Leena on how to perform pelvic rocking while leaning over the bed. (It is my experience that if the infant is in a posterior position, pelvic rocking and increased mobility assist the infant to rotate.) The nurse continued to discuss back labor with Leena and about the posterior position of the infant. She demonstrated the pelvic rock while leaning forward and Leena readily followed her directions. Her husband then was encouraged by the nurse to massage Leena's back while she leaned over the bed. The nurse then retrieved a heating pad that she applied to her back. She then instructed her to breathe the nitrous oxide in that would help her with the pain. Leena followed her instructions without question.

Leena was assisted to the bathroom by her husband and then returned to bed for a vaginal exam by the nurse. She was found to be 5-6 centimeters dilated. The nurse then readied for an epidural by starting the IV therapy and periodically assessing Leena's blood pressure. Leena continued to labor on her side while her husband continued the back massage.

At 4:30 p.m. the anesthetist arrived to administer the epidural. Leena's husband stood at her side with his arms crossed. In 30 minutes Leena was resting comfortably. The nurse performed another vaginal exam and announced that the baby was turning. She hung an IV bag of oxytocin explaining that oxytocin is often used with an epidural because the contractions decrease.

To pass the time Leena's husband discussed with the researcher the advantages and disadvantages of Finland joining the European Union. He stated, "Finns are too honest, they are dutiful and obedient, they need to be more aggressive". He explained that he thought that the food prices would decrease by 10% which would be an advantage. But as a disadvantage, the Finnish people would be worried about money, that having their own currency is a sign of independence.

Leena complained of increased pressure and the nurse assisted her up to a bedside commode. She instructed Leena to "push to the rectum". Leena tried to empty her bladder but was having difficulty relaxing. The nurse turned on the water and told Leena to blow bubbles in the glass of water offered to her in order to release her urinary sphincter. Leena was unsuccessful so the nurse helped her back to bed and performed a straight catheterization. The nurse then checked Leena's cervix to find that she had progressed to 8-9 centimeters. She instructed Leena to pant with her contractions so that she did not bear down prematurely (before 10 centimeters).

At 6:30 p.m. Leena was instructed to bear down with contractions and push on her side. After a few contractions, Leena was then told to turn to her back and push. Leena then was assisted out of bed and instructed to push while up to the side of the bed, pushing while leaning over. Leena's husband assisted her into the various positions remaining at her side. The nurse retrieved a birth stool and instructed her husband to sit behind her and hold her while she pushed on the stool. The nurse sat on the floor in front of Leena. (The nurse

explained to the researcher that she wouldn't allow Leena to push in this position very long because of the perineal swelling that it sometimes causes.) At 7:00 p.m. Leena was helped back to bed and instructed to continue to pushing while holding onto her socks. Her legs were supported by the nurse's and Leena's husband's hips. The nurse then performed a medio-lateral episiotomy and at 7:19 p.m. a boy was born. The infant was immediately placed on Leena's chest under her gown. Leena's husband hugged them both. The nurse offered to Leena's husband the opportunity to cut the umbilical cord which he did. He then carried his infant boy over to the heated bassinet. Another nurse wrapped the infant in a blanket and handed him to Leena's husband to hold. He smiled and held him closely.

Reflections: Leena appears to value education and being prepared for labor. Her husband brought along a bag of extra clothes and snacks. She stated that she valued his calmness and usefulness. She appreciated the nurse's directions and the fact that "she didn't hesitate". She also claimed that she trusted her nurse and husband and having the continual presence for conversation allowed the time to pass. Her labor was typically back labor; therefore, Leena valued the technology to help her cope with the intense back pain as well as the nurse's suggestions for position changes that would facilitate rotating the position of the baby.

The Birth Story of Seija

Seija appeared at the nursing station in the clinic at 10:00 a.m. with light contractions. She was taken by a nurse to a brightly lighted examining room

and seated in an easy chair. The nurse asked her questions about her history then applied the external fetal monitor. Seija's husband accompanied her into the room and sat next to her. The physician entered the room. Seija removed her shorts and panties for a vaginal exam which revealed that she was dilated to 5 centimeters. The nurse helped Seija change her clothes. She offered her the traditional hospital-provided gown, socks, and sandals. Then the nurse told Seija that she would have to wait for a birthroom to become available as the unit was full. Seija and her husband then retreated to the waiting room to have coffee and wait. She did not appear to be very uncomfortable since she was smiling and talking throughout her contractions.

At 12:45 p.m. Seija and her husband were taken to a birthroom. They were greeted by the nurse who then proceeded to orient them to their room. The room was brightly lighted although there were no windows. The birthing bed was centered in the room with a bedside table next to it. There were many central lines hanging from the ceiling at the head of the bed. In an adjoining sitting room was a twin-sized waterbed. Seija's husband laid himself out on the waterbed and smiled humorously. On the far wall was a mural painted on the wall in blue, gold, and green tones that depicted a woman climbing a stairway. As she climbed the stairs, the stairs appeared to get steeper and steeper indicating an increasingly difficult climb. Finally the stairs turned and the woman at the top was holding a baby, a symbolic reward for the difficult journey, i.e. birth, she had just traveled.

Seija was asked about her family and their involvement in the pregnancy.

This was Seija's third pregnancy; they have two boys at home. Seija expressed that they had attended prenatal classes with their first pregnancy. She and her husband believed that it was very important to include their boys in the preparation for this infant. They had borrowed many books from the library with "drawings" in them; she stated, "they are very curious".

The nurse applied the external fetal monitor belts and assisted Seija to a rocking chair. Seija then requested a straight chair because she had had an accident as a little girl in a rocking chair by tipping over backwards. After situating herself in a comfortable straight chair, a physician entered to rupture membranes. The membranes were ruptured with half of an Alice clamp under sterile procedure. An internal fetal scalp electrode was inserted to record the fetal heart rate. Perineal care which consisted of pouring a pitcher of warm water over Seija's perineum while she laid on a bedpan was provided by the nurse. Seija was given a dry sanitary pad and panties to wear. She continued to lay on the bed; however, appeared to be uncomfortable by frowning. The nurse stood at her side talking softly to her. Seija's husband sat at her head on a stool but was separated by the many lines that hung from the ceiling. Seija turned on her side and the nurse began to massage her lower back with slow, firm strokes.

Seija was then encouraged to stand at her bed by the nurse. Seija stood and rocked herself, holding her back. Her husband tried to soothe her by humorously suggesting that they return in two years to finish this birth experience. The nurse returned with a beanbag chair, placed it on the bed, and

instructed Seija to lean over on it, thereby taking some of the pressure off her back. This appeared to help somewhat but after a few contractions, Seija began to lean over on her husband while he sat on a stool. She smiled throughout her contractions; this appeared to relieve the pain somewhat.

Seija walked to the bathroom, emptied her bladder, then returned to her husband for support. She wrapped her arms around his neck while standing; he stood close to her and held her with his arms as if embracing the pain together. They whispered softly to each other during each contraction. Between contractions Seija turned to explain, "there is so much problems with this bone (she massaged her sacral area); I think that is why I want to stand". They continued on whispering softly to each other with each contraction, holding each other. Her husband lifted her with each contraction as if to assist Seija with breathing by increasing her lung space. Seija then tried the next few contractions by leaning over the beanbag chair on the bed but she soon returned to her husband for his support. The lights were turned lower, the electronic fetal monitor was sounding out the fetal heart rate softly. Seija drank some fresh water and returned to the beanbag chair on the bed.

At 2:00 p.m. Seija stated that she felt she needed to push, "but I know it's too early". The nurse performed a vaginal exam while Seija stood and found her cervix to be 7 centimeters. Her husband continued to hold her during contractions; they continued to whisper softly, Seija whispering into her husband's neck and shoulder during each contraction. Seija drank water after each contraction; she sounded as if she was beginning to bear down at the

height of each contraction. The room was very quiet; the only sounds were the fetal heart rate and Seija's light chest panting with each contraction.

Seija then decided to call the nurse by pressing the signal cord. Another nurse entered and while Seija's husband adjusted the beanbag on the bed, the nurse instructed Seija to pant with each contraction in order to resist the urge to bear down until she reached 10 centimeters. At Seija's request, her husband removed the beanbag from the bed and he helped her onto the bed holding up her head and shoulders for the next contraction. The nurse performed a vaginal exam to find that Seija was 8 centimeters. Her husband stated, "Man can't imagine this".

As the nurse readied the room for the birth, the original nurse brought in a birthing stool for Seija to sit upon. Seija explains that she had had a gymnastics injury to her tailbone when she was young so the birth stool would not help. The nurse suggested medication but Seija refused. She returned to her husband for support with each contraction.

After a few contractions, the nurse suggested that Seija could get in bed, on all fours (hands and knees), and lean over the beanbag. Seija found this to be a better position for breathing and coping with the pain and pressure. She turned over for a vaginal exam which revealed her cervix to be 9 centimeters. She returned to her knee-chest position for a few more contractions. After a few minutes, the nurse suggested that she again turn over for a vaginal exam. During this exam she was found to be 10 centimeters at which time she was instructed to hold onto her socks and push.

The nurse continued to gather the necessary supplies for the birth. After pushing for about 20 minutes, Seija was instructed to push while in a knee-chest position. Her husband stood at her head leaning through the surgical lines that hung from the ceiling. He retrieved a cool, wet washcloth for her forehead. The nurse continued to verbally coach Seija through the pushing; Seija's husband held her head and shoulders. At 3:21 p.m. a baby girl was born in the occiput posterior position (face up). Seija exclaimed that she had dreamed that she was going to have another boy and looked completely surprised and smiling. The umbilical cord was cut, the placenta was delivered into the aluminum pan, the infant was then placed underneath Seija's gown on her chest. Her husband leaned in close to Seija and the infant to examine her closely. They both were smiling and whispering to each other. The silver identification necklace was placed around the infant's neck. Then Seija's husband carefully picked up the infant and took her over to the prewarmed bassinet. Another nurse dried her off and wrapped her in clean, dry blankets. She then handed her to Seija's husband to hold. He smiled and held her close to Seija while Seija was receiving perineal care. Once she was cleaned and dry, the infant was handed back to Seija. They held each other closely and smiled.

Reflections: Since this was Seija's third birth experience, she progressed quickly. She stated that she valued the nurse's presence and directions for alternate positions since she was experiencing back labor. She preferred birth to occur naturally, without medication, but was willing to be medicated after

birth, when it no longer affected the baby. She also valued her husband's presence. He seemed to use considerable touch and holding for her to cope with the contractions. Together they whispered to each other throughout each of the contractions. This appeared effective until the later phases of labor. Seija claimed that she places great importance on her family, on education, and less importance on money. She explained that her husband makes enough money that allows her to continue her study toward a master's degree in teaching English.

The Birth Story of Anna

At 9:00 a.m. Anna was admitted to the birth room and oriented to the room by the nurse. This was Anna's fourth pregnancy having one boy and two girls at home. Anna's husband accompanied her to the hospital. He stood by her side as the nurse applied the external fetal monitor belts to Anna's abdomen. The nurse brought in a rocking chair to which Anna was encouraged to sit. Her husband sat next to her on a stool and quietly observed the electronic fetal monitor. The sound was turned off. The nurse prepared the anesthesia tubing and mask for nitrous oxide by laying it on the bed. She then dimmed the lighting and turned on the radio. Anna's husband moved closer to Anna's side and they softly spoke to each other.

The contractions appeared to be getting stronger as evidenced by Anna holding her head during each one. Her husband took her other hand and held it for her. The contractions as recorded on the fetal monitor strip appeared to be about 3-4 minutes apart. Anna asked her husband for a towel; he retrieved

it for her. They whispered to each other; the lights remained low. It became increasingly quiet in the room.

The nurse entered with four others. She introduced them to Anna and her husband. They reviewed the chart and admission papers. Anna's husband arose and moved off to a corner of the room. One of the group members stepped over to Anna and they talked for a few minutes. The group then left. Anna looked at her husband, disconnected the fetal monitor belts, and then took a towel off the table and went to the bathroom for a shower. Her husband followed her into the bathroom.

Ten minutes later Anna emerged from the bathroom with a robe on, applied a clean, dry pad and panties, and sat in the adjoining family room off to the side. She laid down on the couch resting her head on her husband's lap. They held hands. She explained that the contractions had started in the middle of the night. Her first labor had lasted 43 hours, her second labor was 15 hours, and her third labor was 13 hours.

The nurse entered the room and reapplied the external fetal monitor belts. She wrote on the chart, dimmed the lights again, and left the room. Only the sound of the radio could be heard. The nurse then entered with a tray of assorted juices which she offered to Anna. Anna moved to the rocking chair once again and drank her juice. Her husband stared intently at the electronic fetal monitor. They held hands and whispered softly to each other. She rocked in the chair, dabbed her eyes with her gown. She groaned with each contraction. They whispered to each other and continued to watch the fetal

monitor. Anna increasingly frowned with the contractions; the music was changed to classical by the nurse at Anna's request.

At 10:45 a.m. the nurse entered and helped Anna back to bed for a vaginal exam. Her husband stood off to the side. The exam revealed that her cervix was 3 centimeters and the presenting part was still high. She explained to Anna that she would ask the physician for an order for pain medication. She assisted Anna up to the bathroom instructing her to leave the fetal monitor belts on and simply carry the wires with her. Then all she would have to do when she returned would be to plug in the wires into the monitor.

Anna returned from the bathroom, plugged the wires into the monitor, and then sat in the rocking chair once again. She adjusted the belts around her abdomen so that they would record the contractions and fetal heart rate accurately. The nurse returned with the medication and after helping Anna back to bed, she injected it intramuscularly into her hip. Anna's husband gave her some juice. The fetal monitor belts were readjusted and the nurse handed her a thermometer to take her axillary temperature.

A half an hour later, Anna was assisted by her husband back up to the rocking chair. Her husband sat at her side on a stool. The contractions appeared to be getting increasingly uncomfortable. Anna signaled to the nurse. Once the nurse arrived, she handed Anna the nitrous oxide tubing and mask and instructed her to begin breathing in the gas with each contraction. Once she mastered the technique, she appeared to be relieved of the intense pain of the contractions. She asked for some magazines to read to help pass the time.

At 1:15 p.m. Anna's membranes were ruptured by the physician. A vaginal exam by the nurse revealed that she was 4-5 centimeters. Anna appeared to feel more intensity with the contractions as evidenced by her facial grimacing. She held her husband's hand more tightly with each contraction. The nurse readied the room for the birth.

At 1:45 p.m. The physician entered to administer a paracervical for relief of cervical pain. The vaginal exam during the procedure revealed her cervix to be 7 centimeters. Anna turned to her side; her husband began to massage her back. The nurse retrieved a heating pad and began to instruct Anna to pant with her contractions in order to prevent the urge to bear down. The nurse massaged her back also. Anna began to groan and the nurse continued to coach her to pant and breathe with each contraction.

At 2:30 p.m. the nurse performed a vaginal exam to find that Anna had reached 10 centimeters. She was instructed to push with contractions. Twelve minutes later Anna delivered an infant girl. The infant was placed underneath Anna's gown on her chest. The traditional silver identification necklace, a twelve inch sterling silver chain with a plate engraved with a number, was placed over the infant's head. Anna's husband stood at her side. He assisted, at the nurse's suggestion, to cut the umbilical cord and then he carried the infant over to the prewarmed bassinet. The infant was dried off by the assistant nurse and then wrapped and handed to Anna's husband. He carried the infant over to Anna who smiled.

Reflections: Anna's birth experience progressed quickly although she claimed

that this birth experience was harder than her others. She concentrated during her contractions and verbally communicated very little to the nurse or her husband. She held hands with her husband and he cried at one point during her labor. They appeared very close and private. She stated that the massage and touch from her husband and the nurse were most helpful and important for her to cope with the pain.

The Birth Story of Sanna

Sanna arrived in the clinic at 11:00 a.m. with moderate to strong contractions. She was one week early according to her expected delivery date of August 8, 1995. Her husband accompanied her to the hospital and was waiting in the hallway as she was assisted by the nurse to change into the traditional hospital gown, socks, and slippers. She was then accompanied by the nurse and her husband to ambulate to the birthroom, stopping once along the way for her to cope with a contraction. Sanna entered the birthroom and walked over to the window, leaned over to have another contraction. It appeared that she could concentrate most effectively by standing and leaning over during contractions.

Her husband unloaded his backpack and took a video camera out and began to videotape Sanna and the room. No lights were on; the only the light was from the window that had been opened. The flowered curtains were blowing in the slight breeze. The room was very quiet. Sanna entered the bathroom. Her husband retreated to the car to pay the meter for parking and for some food that he had packed.

The nurse entered just as Sanna emerged from the bathroom. The nurse assisted Sanna onto the bed and examined her by performing Leopold's maneuvers and applying the external fetal monitor belts to her abdomen. She then retrieved tubing and a mask for the administration of nitrous oxide if Sanna should choose to use it. Sanna stated that she had had no complications during the pregnancy. She and her husband had taken classes to prepare for childbirth but claimed, "I don't think they were useful". Her contractions had started during the evening prior and she had only slept 3 or 4 hours during the night. At 5:00 a.m. the contractions increasingly came more frequently at 5 to 10 minutes apart. She stated that she felt that she was going to have a girl but she really didn't know for sure. Her husband returned and changed his clothes into scrub clothes offered to him by the nurse.

The nurse brought in a rocking chair for Sanna to sit and rock with contractions. She then instructed Sanna on the use of the self-administered nitrous oxide for pain management. Sanna continued to concentrate with each contraction by closing her eyes and rocking back and forth. The nurse offered to turn on the radio; Sanna preferred classical music to help her relax.

At 11:45 a.m. Sanna tried the nitrous oxide gas. She breathed in and out into the mask but shook her head and took it away. She continued to rock with her eyes closed during the contractions. She began to breathe more deeply with each contraction. She stated that the gas gave her a really strange feeling. "I never used drugs but that is what it must feel like". She continued to cope with contractions with the rocking and breathing.

At 12:30 p.m. Sanna began to resort to using the nitrous oxide again. Her husband sat off to her side on a stool at time massaging her shoulders, holding her hand. Sanna began to relax more but did request the epidural from the nurse. The nurse notified the physician regarding her request. The physician entered to rupture membranes and check on Sanna's progress. A vaginal exam revealed her cervix to be 4 centimeters; the membranes were ruptured; the internal fetal electrode was applied. The nurse performed perineal care and helped Sanna to apply a clean, dry sanitary pad and panties. The she prepared for the epidural by initiating IV therapy. Sanna's husband sat close to her and leaned in to whisper to her during the contractions. He talked softly to her and massaged her shoulders. The contractions appeared to be increasing in intensity as evidenced by Sanna's facial grimacing, increasing breathing rate, and her crying out in pain.

The anesthetist entered the room at 1:00 p.m. to administer the epidural. Sanna's husband continued to provide support by leaning very close to her, whispering softly, and holding her hands. After about 15 minutes, Sanna appeared to be relieved of some of the discomfort with contractions. The nurse performed a vaginal exam to find that her cervix was still at 4 centimeters. She handed clean sanitary pads for her to maintain a dry perineum.

Sanna complained of increased pressure and the nurse again performed a vaginal exam to find that her cervix had changed from 4 centimeters to 8 centimeters. The nurse retrieved a bedpan and asked if Sanna could empty her bladder. After Sanna tried for a few minutes, the nurse then performed a

straight catheterization. Another vaginal exam by the nurse revealed her cervix to be 9.5 centimeters. She hung another liter of fluid for the IV.

At 2:15 p.m. Sanna requested the nitrous oxide again as the effects of her epidural were beginning to wear off. Another half hour passed and the nurse entered to perform another vaginal exam to find that Sanna's cervix was now 10 centimeters. She was instructed to push. Her husband stood by Sanna's side as she pushed. He leaned over her periodically as if to hug her. He stroked her hair after removing her headband which he placed over his own head as if to symbolically take on some of the pain for her. The nurse encouraged them to try various positions to push. Sanna pushed on her side and then tried pushing on her back while grasping her knees and pulling back. Sanna's husband supported her shoulders.

The physician entered to perform a vaginal exam and Leopold's maneuvers as if to confirm that Sanna was making progress. He spoke to Sanna and her husband to explain his exam and possible concern for their infant's ability to tolerate the labor any longer. Sanna's husband continued to stroke her hair, hold her hands, hand her the nitrous oxide mask for relief.

At 3:15 p.m. another nurse entered (change of shift) with a cart on which were placed stirrups, a vacuum extractor, and the delivery pack. Sanna's husband appeared very helpless but he continued to hand Sanna the nitrous oxide mask and then he placed a cool, wet washcloth on her forehead. The stirrups were placed into the birthing bed and adjusted according to Sanna's legs. The physician again entered and prepared to perform a fetal scalp blood

sample with the nurse's assistance. A small sample of fetal scalp blood was siphoned through a long capillary tube and sent to the lab to determine if the infant was experiencing respiratory acidosis.

But Sanna's pushing efforts appeared to be making progress as the physician decided to apply the vacuum extractor and with a mediolateral episiotomy delivered a girl at 3:24 p.m. Sanna's husband leaned over her to hug her. Sanna appeared very angry or concerned by her facial grimace. The infant was placed carefully on her chest underneath her gown. Sanna's husband then picked up his video camera and videotaped both Sanna and their infant girl. Her husband then carefully picked his infant daughter up and carried her over to the prewarmed bassinet. He carefully laid her down and then touch her face and hands. She was dried off by another nurse and then wrapped and handed to Sanna. They both inspected their infant daughter and smiled.

Reflections: Sanna appeared to be prepared for labor as evidenced by her questions; however, she stated that the classes "didn't help". She described her labor as "rather mechanistic" which would lead me to believe that her expectations were not met. She explained that the nurse did not offer explanations of procedures or suggestions to help her cope with the pain other than medication. Sanna claimed that she had wanted to stand and try different positions while pushing. She seemed very self-aware of how her body needed to be positioned to birth this baby. However, her instincts appeared to be denied with the medical intervention necessary for the delivery. The presence

of her husband for labor was appreciated although she had planned to use medication for the pain. She highly values family and education. She appeared disappointed with her birth experience which was evident on her face after the birth.

The Birth Story of Mirja

Mirja sat in an easy chair in an examining room in the clinic at 10:00 a.m. The room was brightly lighted by the sunlight streaming in the open windows. The nurse applied the external fetal monitor belts to assess her contractions and fetal response to early labor. Then she explained to Mirja that she would need to be examined by the physician to determine whether or not she was to be admitted. The nurse performed a sterile vaginal examination to find that Mirja's cervix was 1 centimeter dilated. Mirja returned to the easy chair to be monitored and to wait for the physician.

The physician arrived at 11:30 a.m. and decided that Mirja was in early labor and could be admitted to the birthroom. The nurse assisted Mirja to change her clothes into the traditional hospital gown, socks, and sandals. They then walked over to the birthroom to be admitted. Once in the room, Mirja tried to telephone her parents who were caring for her 2 1/2 year old son at home. She explained that this was her third pregnancy; she had the one son at home who weighed 3600 grams and was 52 centimeters long at birth. The contractions appeared to be increasing in intensity as Mirja often had to stop ambulating in the room to concentrate on her breathing. Again she tried to call home but there was no answer. She climbed into bed and lay on her side. She

appeared to want to concentrate harder as her contractions were getting stronger. She tried to sleep between contractions awaking only to breathe with her contractions. The room was very quiet.

At 12:40 Mirja's husband arrived from work as a computer analyst with a bag. He retreated into the bathroom after greeting his wife and changed into more comfortable clothes, i.e., sweatpants, a T-shirt, and sandals. The nurse entered and introduced herself. She examined Mirja by performing Leopold's maneuvers and measuring the fundal height of the uterus. She then applied the external fetal monitor belts to monitor the contractions and fetal heart rate. She then explained to Mirja that pain medication was available to her if she needed it.

Mirja continued to lay on her side, appearing to sleep between contractions, but breathing with each one to cope with the pain. The contractions appeared to be occurring at a frequency of 5 minutes. Mirja occasionally watched the fetal monitor. Her husband whispered softly to her; he stood by her side massaging her shoulders watching the fetal monitor. He tried to telephone home. He assisted Mirja to turn on her other side and helped her adjust the monitor belts. He continued to watch the fetal monitor while the nurse began her paperwork.

At 1:30 p.m. Mirja asked for medication. The nurse gave her an injection intramuscularly. After an hour the nurse performed a vaginal exam to find that Mirja's cervix was now 1.5 centimeters. Mirja asked for juice or water. The nurse brought in both. Mirja's husband sat next to Mirja on a stool and

massaged her back and shoulders with contraction. He leaned in close to watch her face; he watched the fetal monitor closely. Mirja began to breathe harder as time passed. Her husband continued his massage of her lower back. The fetal heart rate could be heard softly beating in the background with an occasional sound made by the fetus kicking against the transducer.

At 3:00 p.m. another nurse (change of shift) entered and introduced herself. She also assessed Mirja by performing Leopold's maneuvers and measuring the fundal height of her uterus. She retrieved some juice for Mirja. She then reviewed her chart and palpated some contractions with her hand on the fundus. Mirja's husband helped her up to the bathroom. The nurse placed clean, dry pads on the bed. Mirja returned to the bed, sat on the edge, leaned over during a contraction, and then laid back down on her side. The nurse proceeded to initiate IV therapy with plain fluid. A physician entered and ruptured Mirja's membranes. The vaginal exam revealed Mirja's cervix to be 2.5 centimeters.

At 5:00 p.m. an anesthetist entered to administer an epidural. Afterwards the nurse reapplied the external monitor belts, assisted Mirja to turn on her side, and then checked her bloodpressure. She then assisted Mirja to try the nitrous oxide gas as an analgesic until the epidural took effect. The nurse talked with Mirja about the pain stating, "the pain is right now". She explained the sensations and feelings and Mirja should be experiencing at this point in her labor. At 5:30 p.m. the nurse explained "now it is helping" (meaning the epidural). Mirja's husband sat on a stool next to her bed in front of her. He had

changed his clothes into hospital-provided scrub clothes.

The nurse hung an IV bag with oxytocin in order to stimulate the contractions. In about 5 minutes Mirja stated that she felt that she needed to bear down. The nurse performed a vaginal exam to find that Mirja's cervix had changed to 4 centimeters. The nurse remained in the room and talked quietly with Mirja and her husband as time passed. Her husband massaged her legs and held her hand during the strong contractions. The oxytocin rate was increased and soon after Mirja stated that she was feeling increased pressure. A vaginal exam found Mirja's cervix to be 6 centimeters; the nurse performed a straight catheterization in order to empty Mirja's bladder. Mirja continued to take the nitrous oxide gas for the increased pressure. She complained of more pressure and after the nurse checked her cervix to find she was still at 6 centimeters, she called for a redose of her epidural.

During the epidural redose at 6:30 p.m., Mirja's husband retreated to the sitting room adjoining the birthroom and ate some food that he had packed. The nurse increased the rate of oxytocin and checked Mirja's cervix again to find that she had progressed to 7 centimeters. She pulled the monitor strip up to Mirja and her husband and showed them the pattern of each contraction, how a normal pattern appears, and how Mirja's pattern compared to the normal. Mirja began to breath heavily at the peak of each contraction. The nurse continued to talk with both of them, remaining at their sides.

The oxytocin was increased again and a vaginal exam revealed Mirja's cervix to be 9 centimeters. Mirja started to use the nitrous oxide gas with the

peak of each contraction. The oxytocin was again increased and after Mirja's cervix was found to be 10 centimeters at 8:00 p.m., she was assisted by the nurse to turn to her other side. It appeared that Mirja did not have the urge to bear down as of yet. The oxytocin was again increased and Mirja was encouraged to bear down gently without holding her breath while laying on her side.

After a few contractions, Mirja was asked to turn on her back and with her head and shoulders elevated by her husband, grab onto her socks and push. The infant's head began to crown and the nurse quickly grabbed a delivery pack. Once the head delivered it became evident that the umbilical cord was wrapped around the infant's neck. The cord was cut and the infant boy was delivered at 8:25 p.m. and dried off vigorously in order to stimulate respirations.

An assisting nurse gave the infant some oxygen by mask to help restore color. He was then handed to Mirja to be placed on her chest underneath her gown. After holding him for a few minutes, Mirja handed him to her husband to carry over to the prewarmed bassinet to be dried off and wrapped in blankets. Her husband then brought him back over to Mirja so she could hold him. The nurses, once finished with Mirja's perineal care, applied clean sanitary pads, and covered Mirja with fresh blankets. They stood next to Mirja to inspect her infant son and congratulated Mirja and her husband. They all waited for pictures to be taken and then cleaned the birthroom up before allowing the new family time to be together. They all left the room to attend to other clients.

Mirja and her husband smiled and thanked them.

Reflections: Mirja claimed to have a better birth experience with this baby than her last because of the nurse that remained with her throughout this experience. Since she has a tendency to have large babies, she was very appreciative of the technology available to help her cope with the pain. She also claimed that her husband's presence was very helpful and important to her.

The Birth Story of Teija

At 9:30 a.m. Teija came to the clinic to see the nurse for initial assessment with the electronic fetal monitor. She sat in an easy chair with her own clothes on. The external monitor belts were applied to her abdomen and adjusted to record the fetal heart rate and contraction pattern. After 15 minutes she proceeded into the examining room to see the physician for further evaluation. Her 3 year old son at home was born by Cesarean birth because of fetal distress. After the physician performed a vaginal exam, she recommended that Teija go to the x-ray department to determine actual pelvic and fetal head measurements since the fetus's head was still high in the pelvis. Teija began to cry. Her husband tried to comfort her by talking softly and patting her shoulders.

As Teija waited for the nurse to release her to go to x-ray, she explained that they had come to the clinic a few days prior to this in early labor and were told then that they either could stimulate labor artificially with PG gel or perform another Cesarean birth then. Both Teija and her husband decided that it was

best to "go naturally" so they decided to wait until contractions started on their own. So three days later since she was contracting on her own, they decided to come to the clinic. She explained that she was now very disappointed that she may still have to have a Cesarean birth.

At 10:30 a.m. Teija and her husband proceeded to x-ray which was located one floor below the clinic. They were then told that the x-ray indicated that there would be plenty of space for the fetus to be delivered vaginally. They were then taken back to the clinic where Teija changed her clothes into the hospital gown, socks, and sandals. They walked over to the birthroom and were admitted at 12:30 p.m. The room was very dim. Only the light from the window was evident. The nurse oriented them to the room and then applied the external fetal monitor belts to Teija's abdomen. Teija's husband, an electronics engineer who had studied in Italy for five years, had purchased some food in the coffee shop and began to eat. The nurse explained to Teija that the physician will come to instill the PG gel and then she must lie down for one hour and hopefully the contractions would then increase in frequency and intensity. Teija's husband sat on a stool next to Teija's bed.

At 1:15 p.m. the physician entered the room and after introducing himself, he discussed their previous birth experience. He then inserted the PG gel during a vaginal exam and then left the room. After about 45 minutes Teija stated, "the contractions are quite painful already". Teija asked the nurse for something to eat. The nurse checked Teija's bloodpressure, brought in a rocking chair, then retrieved some vegetable soup for her to eat. Teija then got

up to the rocking chair and ate her soup. Teija didn't appear too uncomfortable as she rocked and discussed her travels during the contractions. She explained that she had worked as a travel agent for the airline Finnair. She also discussed with the researcher her pregnancy and care during her pregnancy which included the use of the sauna on a daily basis. The sauna allowed her to maintain cleanliness and relaxation after a day's busy activities with her 3 year old son. Teija appeared to have no knowledge of the current issues with regard to high temperature exposures during the first trimester leading to hyperthermia possibly associated with central nervous system defects and failure of neural tube closure (Milunsky, et al, 1992).

(Towards the evening Teija was transferred to the postpartal unit because of her early labor status. Her husband was sent home to sleep but was called in the middle of the night because her contractions progressed to a more active labor. She was transferred back to the birthroom.)

At 5:00 a.m. Teija's cervix was found to be 4-5 centimeters. The anesthetist entered the room and after a brief history, administered the epidural. The nurse initiated IV therapy with oxytocin in order to stimulate the contractions. Decelerations in the fetal heart rate were being monitored by the nurse with the fetal monitor. She assisted Teija up to a portable bedside toilet in order to empty her bladder and bowel. She was helped back to bed and then began to vomit. The nurse helped her clean up and then increased the oxytocin. She instructed Teija on the use of the nitrous oxide. A vaginal exam by the nurse revealed Teija's cervix to be 7 centimeters. Anesthesia was called in order to

redose her epidural. As she was receiving the redose of anesthetic agent, Teija continued to breathe in the nitrous oxide with each contraction. The only light visible was the light from the window and the warmer light over the bassinet. Teija's husband remained at her side holding her hand and observing the fetal monitor.

At 6:30 a.m. Teija complained of increased pressure and more fluid being expelled. She appeared to be coping with the contractions as she discussed the Finnish tradition of placing children outside in their carriages for fresh air on balconies or porches for their naps. "But we don't do that if it is below 10 degrees Celsius."

In order to pass the time, Teija went on to discuss her previous birth experience as one with which she was very dissatisfied. She had been hospitalized for one month prior to the birth because of "toxemia". She stated that she really liked the women physicians at this hospital. "Maybe women are more suitable for this profession". This lead the researcher to speculate that Teija probably had been referred to a male physician with the previous pregnancy that perhaps did not take the time to explain the risks of hypertensive disorders in pregnancy.

The nurse continued to increase the rate of oxytocin and at 7:00 a.m. a vaginal exam revealed her cervix to be 10 centimeters. Teija was instructed to turn to her other side; her husband kissed her and held her hand. The nurse turned on the radio to listen to the morning news. As the fetal heart decelerations continued, the nurse decided to turn the oxytocin down to a

slower rate of infusion. She instructed Teija to push while laying on her side. After a few contractions, the nurse increased the rate of oxytocin again. She raised the head of the bed and gave Teija tubing and a mask through which oxygen was given in order to help the fetus. Teija was instructed to turn to her back and grab her socks and push. The nurse retrieved a second pillow to help raise her shoulders. Teija's husband moved to the head of the bed to help hold Teija's shoulders. Tieja turned to her other side and continued taking in oxygen while pushing. The nurse stepped out to call the physician at 7:30 a.m. She quickly returned and stated "Without that last epidural (redose), the delivery would have happened earlier".

The physician entered, performed a vaginal exam and without saying anything left the room. Another nurse entered (change of shift) and performed another vaginal exam. The oxytocin was again increased. The physician again entered, performed another vaginal exam. He waited at the bedside while the nurse performed a straight catheterization to empty Teija's bladder. Teija then was instructed to resume pushing. Teija placed her feet on her husband's and the nurse's hips for support. The other nurse applied a vacuum extractor and performed a mediolateral episiotomy. As the physician observed, an infant girl was then delivered at 8:17 a.m. "It was wonderful" cried Teija. Her husband openly cried. The nurse dried off the infant and held her up for both to see. The baby was wrapped in a blanket by an assistant nurse and handed to Teija's husband. He held her close inspecting her face. He then carefully handed her to Teija for her to hold. They both cried. The assistant nurse then took the

infant girl to the nursery for initial assessment, evaluation, and measurements while Teija was undergoing the surgical repair of her episiotomy. She appeared to be quite pleased with her care as evidenced by her smiling face and excited tone of voice. Both nurses congratulated Teija and her husband. Reflections: Teija's first birth experience was a Cesarean birth; therefore she was anxious to deliver this baby vaginally. She had a long labor which was facilitated with analgesia and anesthesia, but successfully delivered vaginally. She stated that the nurses' presence and her husband's emotional support were most helpful. She desired to have the technology of pain relief but knew that her epidural redose was too high, thereby delaying the birth. Her birth was a highly emotional experience as both she and her husband outwardly cried.

Part 2

Interviews

Following each of the key informants' birth experiences, the researcher conducted an interview on the postpartal unit with all of the key informants in order to confirm the handwritten field notes and recorded participation-observation-reflections. As described earlier, the interviews were held as important to gain insight into the informants' emic and etic perspectives with regard to generic and professional care meanings and practices. The interviews after the birth experiences captured what the informants had experienced. As the researcher and family witnessed, there seemed to be no gaps in recalling the experience as it was still vivid, personal, and meaningful.

The researcher developed and used the Ethnodemographic Inquiry Enabler

(see appendix B) which is structured in three sections. The first section of the enabler was developed to gather basic information about the key informants with name, age, expected delivery date, gravida and parity status, place of birth, actual date of delivery, the infant's gender, the generic (emic) caregivers, and the professional (etic) caregivers. The second section was designed to elicit the key informants' emic perspectives concerning factors using the Sunrise Model dimensions in relation to the theory. Open-ended inquiries were used to facilitate informant's sharing of their beliefs and values regarding worldview, ethnohistory, cultural values and lifeways, kinship, education, language, economics, politics, technology, religion, and their environment. Section three of the enabler guide was designed to discuss the current pregnancy and birth experience. Inquiry leads were used to elicit information regarding their prenatal care experiences, any formal or informal kinds of educational preparation for birth, and any decisions planned regarding choices about their birth sites and/or care providers.

Discussion followed each inquiry which focused on the generic and professional care meanings and practices for each of the key informant's birth experiences. Observations of the researcher were shared with each of the key informants which led to their recall of their birth experiences. During this process, the researcher confirmed observations and participation of key informants with generic and professional care practices. Their meanings as expressed by the key informants were systematically documented by written and taped recording.

Leininger (1995) defines worldview as, "the way people tend to look out on the world or on their universe" (p. 105). Worldview is "the way an individual or group looks out upon and understands their world to provide a value stance, picture, or perspective about their life and the world" (Leininger, 1997, p. 38). With each of the key informants, four of the ten key informants were born in Helsinki, the largest city and capitol of Finland; two were born in or near Kuopio, another major city in the lake district of northern Finland. The remaining four were born in small villages, but all were currently living in or near Helsinki at the present time. All key informants had grown up in average size families ranging from one to five children. In Finland the average number of children has been as low as 1.78 children per family (STAKES, 1995). All ten key informants, having been born and raised in Finland, had positive comments regarding their country, i.e., that they highly valued being Finnish, that they were proud to say they were from Finland.

Their worldview was expressed by comments regarding their young, independent heritage and their struggle for identity in the world as a small but important nation. This pride for their homeland appeared evident in both the data from the participant-observation-reflection of the birth experiences and from the interviews. One key informant who left Finland to work for the Finnish Ministry of the United Nations in Geneva, Switzerland, returned home so that their infant could be born in Finland. One general informant identified the differences between American and Finnish people, stated that Finnish people are "shy, law abiding people, with a sense of duty", whereas Americans are

assertive and self-indulgent, working more for the good of themselves rather than the good of the people. Another general informant confirmed this by describing Finns as being "too honest; they are dutiful and obedient." One key informant poignantly said, "I love it [Finland]; I believe in Finland and believe in Finnish people and so on that I was one month where I go to Italia and Espania...when I get back to Finland we came to boat and I see Helsinki and I see white church and I cry."

A keen sense of national identity, stemming from the political domination by either Sweden or Russia, was reflected both in the Finnish language which is a difficult and unique language to learn and in its folk history which was transmitted orally for centuries and written down in the 19th century. The *Kalevala* has provided the centerpiece for Finnish nationalism that culminated in the declaration of Finnish independence on December 6, 1917. The *Kalevala* which is often called "Finland's epic poem" sought to preserve old customs and songs and portray the mythical Finn as powerful only if good and just. The author Elias Lonnrot generated a national pride with this record of folk poetry and is honored not so much for the quality of the *Kalevala* (Lonnrot, 1835), but how it raises the status of the Finn as a legendary participator in the creation of the world (Woolnough, 1994).

Closely aligned with worldview were the cultural values and lifeways that became increasingly evident throughout the data analysis. The key informants all stated that in terms of their values, they held the family in high regard. In conjunction with the kinship social structure factor, the key informants all

expressed that their families were most important to them. Public support for families with children with Finland's national health care policies includes child day care, child home care allowance, a maintenance allowance for children, a child benefit, and a housing allowance with home help services (STAKES, 1995).

All of the key informants had careers outside the home before their first pregnancy. However, because of government social welfare policies, the women are encouraged to remain at home with 10 months paid leave. Such statements to confirm this benefit were, "I get paid and stay home with my baby", and "the parenthood payments can be either the mother or the father for 10 months". And to support the mother working outside the home, "there is a law in Finland that cities have to organize a nursery place for a child under three years." But most importantly verbatim such as, "most of my time is with the children, they are so small, they need me," and "family is the most important thing" affirms their belief in the high regard for family and kinship.

Another cultural value that became evident throughout the data analysis was the value in education and language. All of the key informants completed nine years of comprehensive school. According to the National Association for Foreign Student Affairs (1985), the Finnish comprehensive school consists of two stages: the lower stage (grades 1 through 6) and the upper stage (grades 7 through 9). In the lower stage all of the subjects are the same except for foreign languages which are given special emphasis with specialist teachers.

The first foreign language is English which is required in the third grade.

Swedish is usually the second foreign language which begins in grade seven. All of the key informants had had English in third grade; however, many were quick to add that the English courses were mostly grammatically, not conversationally focused. As one informant related, "most important in school to have a conversation, we read and translate and write and I think the most important is to converse and make it so you have speak ... so you can use the language". One key informant claimed that language was an important part of the Finnish culture "because nobody knows Finnish, so if you want to have some contacts elsewhere you have to speak some other languages because Finnish [Finland] is so small." She also expressed the desire to learn French stating, "because now when you are part of the European Union it's very important language, more important than English because it's the official language in European Union ... everything comes in French first ... their main building is in Brussels and there the French is dominating."

During the birth experiences of six of the ten key informants, when talking with the professional care providers, the nurses often spoke in low tones to the women during labor. This appeared to be comforting and relaxing to the women. One key informant and her generic care provider stood during the contractions, wrapped in each others arms, whispering softly to each other so as to almost express a sensual nature in their ability to draw strength from each other to cope with the pain. According to Peltonen (1994), Finns are known to be reserved and private. It is characteristic of Finns to speak quietly, "even in whispers when conversing in a public place" (p. 22). Loud speech is

considered vulgar; crying outloud in the pain of birth may also be vulgar. Whispering quietly may be a manifestation of the woman's attempt to maintain privacy and a sense of composure which is characteristic of the Finnish people.

After comprehensive school was completed, all ten of the key informants continued their education in one of two ways. Finnish upper secondary education is of two types: vocational education (1-4 years) and the three-year senior secondary school (lukio or gymnasium), which represents the academic general education tradition that prepares the student for university study (National Association for Foreign Student Affairs, 1985). University education is free, but only 15% of the country's eligible students are accepted. Of the ten key informants, five had attended university level institutions. Three were teachers, one a mechanical engineer, and one a dentist. The other five completed the vocational track or gymnasium for upper secondary education: a bookkeeper, a cook, one who works in banking, one who works as an assistant to the Finnish foreign ministry, and one who attended a tourist institute for a career in tourism. One key informant who had a teaching career and was continuing her education beyond the masters level, responded to the researcher's inquiry about the importance of education by, "I don't want to have a better salary or better working place; I don't do the research work for that; I do it for to show myself that I can manage, and I can do it, but I can find something new, but it is always been important for me to study and to learn."

Teenage pregnancy is almost nonexistent in Finland according to the

National Research and Development Centre for Social Welfare and Health (STAKES, 1995). Sex education is included in all educational curricula for 14 and 15 year old pupils, and teachers receive additional training in sex education. All schools provide health services and the school physicians and nurses give lessons and individual guidance concerning issues in sexuality. Topics include physical and psychological changes of puberty, dating, contraceptive use, sexually transmitted diseases, etc. Every 16 year-old receives a packet of information about dating, human relations, sexuality, and family planning via mail which includes a sample condom. The Finnish media has also provided information regarding family planning and sex education. The researcher photographed banners mounted on lightpoles throughout the city of Helsinki freely advertising the use of condoms. Women's magazines have also contained numerous sex-related articles which are read by both sexes.

The number of induced abortions in Finland is one of the lowest in the world (STAKES, 1995). An act concerning induced abortions was passed in 1970 that made it possible for women to claim the right to an abortion based on social reasons. As the new Primary Health Care Act was instituted in 1972, cost for the necessary health examinations "prior to the abortion as well as for the abortion itself were essentially paid by the municipalities" (Kontula, Rimpela, & Ojanlatva, 1992, p. 70). The number of induced abortions was 56% lower in 1993 than in 1973, the total number of induced abortions being reduced from 17,081 in 1976 to 11,071 in 1992 (STAKES, 1995). This trend is

being attributed to the effectiveness of the legal policies that prevent pregnancies. Illegal abortions are no longer performed (STAKES, 1995). Because 98% of Finns are considered Lutheran, there are few individuals that oppose abortion based on religious beliefs.

Almost all mothers and an increasing number of fathers take part in childbirth preparation training which is arranged by public health care services. A study to explore the possible influence of the expectant mother's knowledge of childbirth on the outcome and experience of pregnancy and labor found that low childbirth knowledge is associated with a poorer pregnancy outcome (Rautava, Erkkola, & Sillanpaa, 1991). Therefore prenatal classes or childbirth preparation training is considered of value and important to prevent complications or problems associated with birth. In an earlier study however these same researchers found that of postpartum women's opinions of antenatal training courses, 75% believed that they increased their knowledge but "for those with an already high level of basic knowledge of childbirth, they felt that the information they received was largely out-of-date, inadequate, and poorly presented (Rautava, Erkkola, & Sillanpaa, 1990, p. 353). Only one-third of the women studied believed that the courses had helped them to cope with the pregnancy and delivery; even fewer thought that their anxiety had lessened. As described earlier, all of the key informants had participated in prenatal classes conducted by the nurses in the maternity clinics either with the current or previous pregnancy. The findings of the study were confirmed by two of the ten key informants, one who claimed, "I don't think the [classes]

were very useful".

Closely connected with education and language are the economic and political systems of Finland that influenced the key informants in terms of their family health care and birth experiences. "Finland is a country that will fiercely maintain its cultural and political independence, proud of the fact that it has carved out its own political and cultural destiny" (National Association for Foreign Student Affairs, 1985). Until World War II, Finland had a stagnant agricultural economy. Post-war industrialization however, stimulated economic growth to such a degree that the country was considered rich.

Yet today the East and West view modern Finland in two ways. Some perceive it as an "enlightened, peace-loving Nordic nation that is clean and unspoiled and heroic and healthy" (Peltonen, 1994, p. 61). But others worry that because of its physical and political position with the Soviet Union it may be dominated by Soviet influence. Finland has chosen neutrality as its political place in the post-war world and because of this peace-oriented policy, has eased the tense mistrust of East-West relations through many bargained agreements and compromises.

The Finnish-Soviet 1944 peace agreement included "war reparations of over $600 million" (p. 64). As one general informant confirmed, "we were the only country to pay off the war debt". Ironically though, this debt helped to build the new economy by negotiating the payments in manufactured engineering products such as farming and forestry machinery, and ships. These industries became stable sources of income for the Finnish people contributing to the

economic growth.

In addition to the economic success, another Finnish political stance has been its deep commitment to the peacekeeping functions of the United Nations. Finland "joined the UN after the difficulties of the immediate post-war period were safely behind and the main lines of our policy of neutrality had been laid down" (Peltonen, 1994, p. 64).

The Finnish welfare system as previously described, offers generous state pensioned, free high-quality health care, and good unemployment benefits. Progressive laws guarantee 10 months paid leave (which can be extended) to a mother or father who stays at home with the infant, plus a substantial child benefit payment. These laws have contributed to more new parents staying at home during the crucial early stages of infancy. Attention is also strongly focused on families and health because the birth rate of Finland is low (only 1.7 infants are born to every two adults). The intensive pre- and post- natal care programs and services for mothers and children have improved the perinatal morbidity and mortality rate to six per 1,000, the world's lowest rate (Peltonen, 1994).

As discussed earlier, all key informants had participated in prenatal care services during their pregnancies. In addition, all of the key informants as is the custom were participating in receiving the maternity care package and child benefit payments. The key informants all described that their living accommodations were adequate and comfortable, that all financial needs were being met by their spousal employment and government compensation. The

majority of the key informants lived in apartments. Although rents are controlled and the maximum income tax is now 51%, Finnish real estate has been described as the most expensive in the world (Peltonen, 1994). However, Finland still has a 65% owner-occupied housing because many do not hesitate to borrow. This welfare state gives a sense of security that allows the Finnish people freedom from worries about retirement bills. All of the key informants were planning to return to their employment positions at some future point in time; however, they were all planning to take advantage of their 10 months paid leave first. Once they return to their careers, they can take advantage of the state-subsidized child care centers to offer free care to their children.

Nevertheless, three of the key informants said that these benefits are changing and cuts will have to be made as noted by one who stated,

> "The state is taking so much money abroad, to keep up with all the social benefits and nowadays all the political parties may have to have cuts ... it's hard to decide, being competitive abroad, but it's awful important to maintain services here too."

Another key informant stated when discussing Finnish economics, "But it is so nowadays that the money is getting less so the money is not much anymore and now there is so much unemployed." Later the same key informant repeated Finland's high unemployment rate, "Nowadays there is high unemployment; things are changing and we don't trust anymore the politics." A general informant who described himself to be an economist stated that the current unemployment rate was 17%. Another key informant attributed the country's national debt to foreign policy, "We get the loan from Japan and we

no pay the bank always you see, more and more ... and now we must stop some things social ... it is not right to always pay to foreign money to people".

In exploring these economic aspects, one general informant described this situation as a prelude to the fall of the Finnish economy in 1990 when "big business was buying companies abroad and no collateral from banks was expected ... graduates had many jobs, the unemployment rate was 2-3%, and then increased debts were incurred and the economy fell." He further explained that the unemployment rate then peaked in 1992-93 at a rate of 20-22%. Now that membership in the European Union has occurred, Finland's fears of compromising its neutrality, loss of its deeply rooted agrarian loyalties, and sacrifice of its price-fixing mechanisms that shield industry from real competition have been overcome and the Finnish economy will continue to flourish.

Along with the economic growth, Finland has continued to focus on its technological foundations. According to a study on childbearing practices, almost all pregnant women in Finland are choosing their birth experiences to occur in a hospital setting "where maternity ward nursing and midwifery staff have the needed expertise to bear responsibility for the delivery" (Vakkilainen & Niemela, National Research and Development Centre for Welfare and Health, Finland, 1993, p. 2). The researchers found that improved methods of pain management, better "know-how in delivery care" which allows the caregivers to regard families as "whole entities" in this process, and developed technology that reduces unanticipated complications and eliminates

unnecessary labor inductions all have assisted maternity wards to progress towards becoming more "mother-friendly" (p. 2).

All ten key informants in this study chose their birth experiences to occur at the Central Women's Hospital. For various reasons, they were appreciative of the technological support provided for them. One key informant expressed appreciation for the genetic testing that she had had done due to her age being 37 years. Another stated, when describing that her previous pregnancies were all complicated with premature labor, "I am so problem when I am pregnant and I want that I know that baby is all right". Another key informant shared that they had chosen Central Women's Hospital, that they, "Thought it was wise because of treatment". This meant that their infant would have been transported to this hospital had there been a problem, so it was "only natural". Another key informant who had a history of large infants and postmaturity expressed her gratitude for the ultrasonic testing that enabled her to follow the progress of her infant's growth until labor started spontaneously rather that artificially with oxytocin.

The ten key informants had the electronic fetal monitor applied upon admission to the birthrooms for assessing fetal well being and progress during labor. The key informants had IV therapy initiated at some point in their labors. In terms of pain management, six of the ten key informants used nitrous oxide gas inhalation for analgesia. Only three of the informants had analgesic medication, all were administered intramuscularly. Seven of the ten key informants had epidurals which often necessitated the use of oxytocin

augmentation for the diminished labor contractions and the use of straight catheterization for the resultant loss of bladder sensation. Two of the key informants had paracervicals administered by physicians for cervical anesthesia in the latter phases of labor.

The informants were asked to share any particular meanings or practices of caring provided by their support persons or their nurses that were helpful to them. They were asked to describe in what ways were these practices were helpful to them, what did they mean to them. One key informant described her pain by saying, "I thought that the pain wouldn't be so hard but I feel it was so awesome that I quite tough". The only key informant who had no analgesia or anesthesia stated, "It was a little bit painful but I was so happy that I didn't need anything to make those pains smaller." She also went on to describe her capabilities to cope with labor as,

> "If I know the pain will come and that's something that hurts, then I don't mind about it when to go to the 10 [ten centimeters], then I don't want anything because it's only 20 minutes and I can bear it...I tolerate quite a bit of pain if I know it is coming but if it's sudden so that you cannot know that it is coming then I don't like it at all but if you can think it before that now it's coming and it helps the situation go further and there is some progress then I can bear it."

She also described her progress after her membranes were ruptured as,

> "I felt I get the fast train, too fast for me ... if I could stop it and make it go slower I would have done that but I couldn't, I was on the train and it goes and goes and goes and I had to go with it".

Finally, when the researcher inquired about anything that the woman may have wanted to change about her birth experience, one key informant stated, "It was rather mechanic ... all the machinery and all this new medicine what

they give". In describing her feelings, "I couldn't have anything else but just get rid of the pain." In exploring this further, she explained that she had thought the birth experience would be "more natural ... but during the situation I couldn't think anything else". Nevertheless, she had planned on receiving the epidural, only earlier in her labor. Another key informant whose labor resulted in a Cesarean birth, commented,

> "Of course I was hoping that it would be over sooner, it was too long, I felt that none of my wishes are taken into account and knowing the size of the baby, ... knowing that there was a problem and all that stuff ... it wasn't really considered ... but I trusted that these doctors here and I wanted to try [labor] .. and didn't have a problem but after pushing phase, I kind of got the feeling that it is not going to work".

She later confessed, "I'm just happy that it is over ... I don't think like, I know that some that have sections have somehow failed or something but I don't think that the nurses or doctors failed, but more like on that side".

Other nontechnical measures were often taken to assist the key informants in their birth experiences. All ten key informants were offered the use of a rocking chair. Only one declined who had had a childhood accident in a rocking chair. Other resources offered by the professional care providers were the use of the birthing stools, the bean bag chairs as supports for back labor, the water bed for positional comfort, etc. Two of the key informants used the birthing stools, one used a bean bag chair, and only one general informant, a generic care provider found comfort in the water bed.

About 86% of the Finnish people belong to the Lutheran Church, which supports family planning and sex education. These topics are integrated into

the curricula of confirmation classes. Nine of the ten key informants were identified as Lutheran; however, after being married in the Lutheran church, one had changed to Catholicism. One key informant stated that she had no religious affiliation. She had formerly belonged to the "deliverist church" but left the church for philosophical reasons claiming that the church had forced her to believe in a god, then supported "war". Nevertheless, she did want her children to attend church with her husband because, "I want that they teach morals because I think there are lot of not [morals] in the church ...many years people is lost I think."

Nine of the key informants belonged to a religious faith, but found themselves to be "not very religion". In fact, one key informant stated, "It's part of my life because my mother and father worked for the church ... so [but] it's not the main thing in the life". When discussing church financial support with one key informant, she stated that the state supports the church with tax money. She claimed, "People take their papers away from the church because of the fee" which means that they removed themselves from formal membership. This may have led to the declining membership in the church. It appears that the church is used mainly for marriage, christening, and funeral ceremonies. Religious education is a component of public education, but the church does sponsor a confirmation class retreat for adolescents about to become church members. Finnish custom holds that infants are named at the christening ceremony usually held in the church. It was learned that this could take up to three months; therefore, the infant's name often remains a secret

until the ceremony. Only two key informants were willing to share their infant's names during the interviews on the day following their births.

According to Woolnough (1994) the Finns have used their country's natural environment as a way to convey their national identity. The blue and white flag represents the blue lakes of summer and the white snow of winter. The "literature, fine art, and the design and architecture have all drawn on the environment for a Finnish idiom" (p. 111). An environmental activist once claimed, "we depend on nature and the environment for everything. If we allow our forests and lakes to become polluted, our Finnishness will disappear too. The hearts of the Finnish people lie in the lakes and forests. They are our identity, our capital, and riches". "Green" policies such as recycling, improved home insulation, and public transportation are just a few examples of practices that have been a part of everyday life for Finns. Even design specialists make every effort to produce products that use minimal raw materials, use maximal recycled or recyclable materials, use minimal energy during manufacturing, and have the longest possible life.

The Ministry of the Environment was established in 1983 and a general assessment of the country's problems revealed that the basic concerns are ones share by industrial nations everywhere: minimizing air and water pollution, energy conservation, preservation of natural landscape, saving endangered species, and promoting waste management (Woolnough, 1994). Environmental policies in Finland link this emerging commitment to "ecologically sustainable development, prevention and control of risks, and the

equitable access to healthy living" (STAKES, 1995, p. 7). The Finnish government views the environment as an assessment of total quality of life and believes that everyone should be able to live in communities that provide social and physical support systems. Most of the key informants could express appreciation for the importance of their environment in their lives. Many used the outdoors for sporting activities, family outings, etc. Many retreated to cottages during the summer months, spending many weeks in remote areas, often without electricity. One key informant, who described the professional care during her birth experience as, "they were gone most of the time, there wasn't anybody there" claimed a possible explanation. "I think it was because it is summertime; I think lots of people are on vacation and there were maybe not all the personnel there".

More specifically, the environment of the birthrooms as described previously was quite modern with a highly technical appearance. The birth rooms were private, had their own toilet and shower facilities. Some had an adjoining family room; most had windows that could be opened for fresh air. Attempts have been made to enhance a more home-like appearance in some of the birthrooms with the use of flowered curtains, matching bedspreads, painted murals, etc. Nevertheless, because most of these rooms were remodeled surgical suites, the birthing beds had to be positioned in the center of the room in order to have access to electrical and gas lines that hung from the ceiling which gave the environment a more "sterile" impression.

Despite this, none of the key informants negatively commented on their

birthing environments. Generic and professional care was more meaningful to the key informants than the hospital environment in which they gave birth. Home birth is not practiced in Finland. Finnish women choose the hospital, as opposed to their home, as their environment to give birth because of their trust in medical technology and professional care. The hospital's efforts in creating more comfortable, pleasant birthrooms was simply to meet the birthing woman's aesthetic needs for relaxation and comfort and to facilitate the transition of the woman and her newborn to home. Because Finnish women are assigned to their regional hospital based on their geographical district, there is little need for competitive redesign of birth units to attract women's health care services.

Table 1

Ethnodemographics of Key Informants

Informant	Age	Profession	Religion	Gravida Para	EDC DOD	Anesthesia	Baby Sex
Pirkko	37	teacher	Lutheran	1, 0	7-6-95 7-20-95	E N2O med	M
Anneli	38	dentist	Lutheran	5, 4	7-7-95 7-20-95	N2O	M
Elisa	27	ministry	Lutheran Catholic	1, 0	7-14-95 7-26-95	med N2O para- cervical E	M
Linea	28	bookkeeper	none	3, 2	7-14-95 7-24-95	E	F
Leena	32	engineer	Lutheran	2, 0	7-22-95 7-25-95	N2O E	F
Seija	33	teacher	Lutheran	3, 2	8-5-95 7-31-95	none	F
Anna	30	cook	Lutheran	4, 3	8-6-95 8-1-95	med para- cervical	F
Sanna	28	teacher	Lutheran	1, 0	8-8-95 8-1-95	N2O E	F
Mirja	35	accountant	Lutheran	3, 1	7-20-95 8-2-95	E	M
Teija	34	travel agent	Lutheran	2, 1	7-21-95 8-4-95	N2O E	F

Part 3

Themes

Using Leininger's four phases of data analysis, five major themes, four

universal and one diverse, were identified. Two of the themes reflect generic care meanings and practices and two reflect professional care meanings and practices. A final theme of diversity as it relates to Culture Care theory is presented. Brief descriptions of each theme supported with verbatim descriptors, observational descriptors, and patterns and are presented in this section.

Universal theme one: Generic care meanings and practices meant comfort care with physical presence and touch from family.

All key informants agreed that they had preferred to receive care from a family member during their birth experiences. However, not all of the key informants had a family member physically present. Due to the nature of an unexpected onset of labor, one key informant was unable to notify her sister before the birth. One key informant's husband was working out of the country and was unable to travel to Finland at the time of birth. Both explained that they had planned to have a family member with them but expressed confidence and trust in the professional care provided to them since they both were multiparas and had previously experienced birth.

Verbatim descriptors of the key informants such as "He was there to comfort me," "I want him to be here," and "I'm here to take care of you" revealed a sense of comfort in having a family member present during their birth experiences. The generic care providers observed were spouses of the key informants. Other descriptor statements were, "His nurse was also quite satisfied with his work so he thought that he wasn't fainting or just be present"

and "Maybe he's hesitating or maybe he's not so relaxed, but he doesn't show it and I really like that" reflected the womens' appreciation for the abilities and confidence of the generic care providers to offer care to them.

Ten key informants all described what physical care measures were meaningful to them. Some shared that massage of the back and arms, wiping of the face with a cool washcloth, and holding hands to be most helpful. Others said that holding, kissing, and whispering softly to them during the contractions was effective. One key informant revealed, "Although it's impossible, it felt like that he takes away some part of the pain."

Verbatim Descriptors: (See visual Illustration 1)

The verbatim descriptors included "He was there to comfort me"; "I want him to be here"; "I'm here to take care of you"; "His nurse was also quite satisfied with his work so he thought that he wasn't fainting or just be present"; "Maybe he's hesitating or maybe he's not so relaxed, but he doesn't show it and I really like that"; and "Although it's impossible, it felt like that he takes away some part of the pain."

Illustration 1

Physical Presence

Observational Descriptors: (See visual Illustration 2)

The observational descriptors included holding, kissing, whispering softly, massage of the back and arms, wiping of the face with a cool washcloth, and holding hands.

Illustration 2

Physical Touch

Patterns: (See visual Illustration 3)

These verbatim and observational descriptors were further supported by the patterns of behaviors. The patterns were derived from recurrent descriptors and from extensive detailed and repeated findings. The patterns that became evident throughout the analysis of the descriptors included

1. Comfort care meant physical presence, being near, being with the key informant during birth.

2. Comfort care meant touching or stroking, massage, holding, whispering softly to the key informant during birth.

These patterns of care provided by the family or generic care providers consistently appeared throughout the birth experiences as recurrent

observations and were confirmed in the verbatim from the interviews held on the following day.

Illustration 3

Comfort Care

Universal theme two: Generic care meanings and practices meant <u>protective care with empathy and trust</u> from family.

Key informants described that having their husband with them for the birth was "wonderful". More specifically, key informants described the generic care as provided was more emotional than physical, i.e. "Just sympathy because he couldn't do actually anything to help, and he was there, that was most important." Other verbatim descriptors confirmed this pattern, "Men don't do so much, they can just do so much, but they are there for support." "If something happens for the baby, they have to be there, I guess more mental."

Eight of the key informants stated their appreciation for generic care as emotional presence with their husbands. "That was one thing very good and I think that he was there very helpful, I know I can trust him." Another comment that supports the theme of protective care were comments that spoke to the importance of safety. "He was a good help, it maybe looked like he don't do anything but I thought it so that when he is near, it's safer for me and when I can hold him it helps me to bear this pain." After their birth experiences, two of the key informants commented that having their husband with them made them feel safer. "I'm very happy and now it feels safe."

Verbatim Descriptors: (See visual Illustration 4)

The verbatim descriptors included "Just sympathy because he [husband] couldn't do actually anything to help, and he was there, that was most important"; "Men don't do so much, they can just do so much, but they are there for support"; "If something happens for the baby, they [family] have to be there, I guess more mental"; "That was one thing very good, and I think that he [husband] was there very helpful, I know I can trust him"; "He [husband] was a good help, it maybe looked like he don't do anything but I thought it so that when he is near it's safer for me and when I can hold him it helps me to bear this pain"; "I'm very happy and now it feels safe [with husband]."

Illustration 4

Safety

Patterns: (See visual Illustration 5)

These descriptors led the researcher to identify certain patterns of generic care that the key informants found to be most valued. The patterns identified were

1. Protective care meant the support provided from family offering empathy or sympathy during birth.

2. Protective care meant the trust and safety offered by family during birth.

These patterns of care provided by the family encouraged key informants to concentrate on the task of birth without having to expend needless energy on concern for their well being.

Illustration 5

Trust

Universal theme three: Professional care meanings and practices meant <u>ritualized care to build respect and trust</u> with the key informant.

Ritualized care was defined as care from professional nurses that included daily procedures and routines that were known, expected, and standardized by the institutional setting. The rituals of care were those activities that had explicit criteria and expectations to judge or evaluate the nurse's actions. These rituals were normative expectations held by the profession to improve or maintain quality of care. The rituals of orientation to the birthroom, physical assessment, implementation of comfort measures, evaluation of labor progress, and preparation for birth were found to provide consistency, rhythmic repetition, order, and stabilization as the intensity of the birth approached.

Nevertheless, the care rituals observed required high level decision-making based on professional education and experience with women in birth and on deeply imbedded knowledge of generic cultural caring practices which are meaningful to women in birth.

Verbatim descriptors from the key informants indicated the importance of continuous presence of the nurses as they carried out their ritualized care with such statements as, "She [nurse] was there with me, like family" and "She [nurse] was holding my legs, massaging my feet and back." Three of the key informants spoke about the continual presence by the nurse as effective. "She [nurse] was the only nurse and knows what happened beginning to end" and "They [nurses] did what I needed." This also became evident in such statements as, "It was so beautiful, being calm, having her [nurse] with you for all the time." This was a concern for one key informant who especially expressed concern over being left alone, "She [nurse] was there quite alot because I have heard that some of those peoples [nurses] can be away one hour, so she was there."

Certain statements implied that trust was a valued concern for the key informants. "All the things she [nurse] did, she wasn't hesitating or didn't take long, I trusted her [nurse] and it was very good." Also, one key informant in describing her care from the nurse said, "It helps with the pain and trust."

The key informants described the nurses' professional care by listing the nursing rituals that were task-oriented procedures and protocols, observed by the researcher for each of the key informants during their birth experiences.

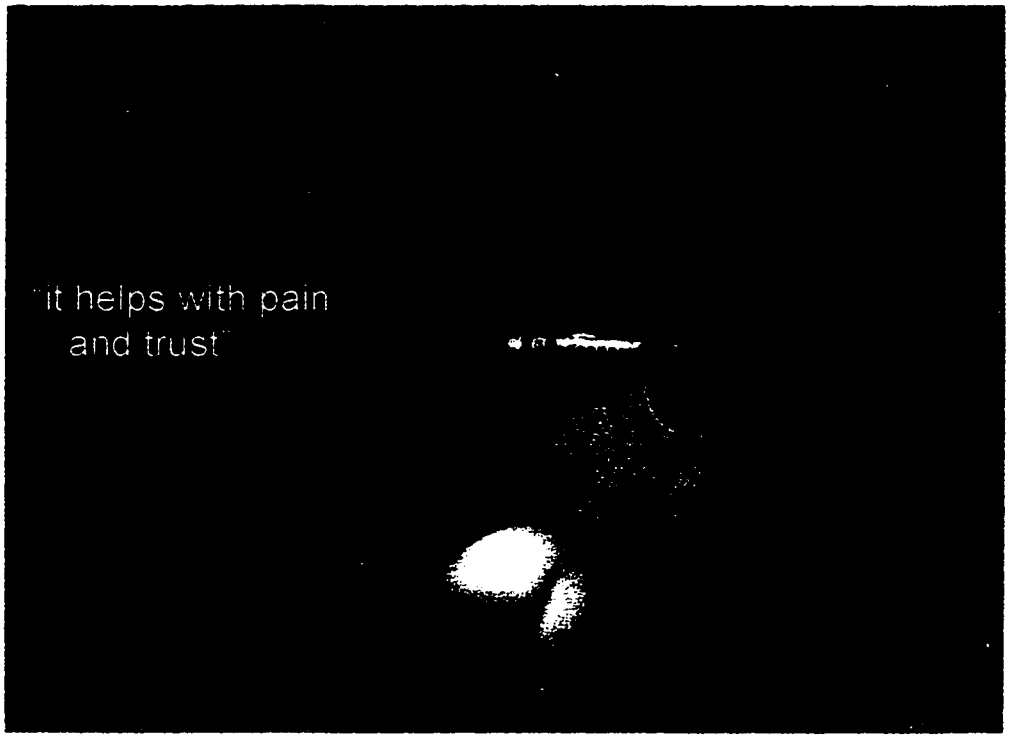
These observational descriptors included orientation to the birthroom, assessment by performing Leopold's maneuvers and applying the electronic fetal monitor, IV therapy, documentation, etc. Care rituals were consistently evident for each of the key informants: providing comfort measures throughout labor either with intramuscular medication administration, nitrous oxide gas inhalation, or notifying anesthesia for epidural administration, and other care practices such as suggesting position changes, offering a cool washcloth or massage, bringing juices and yogurt, etc.

Verbatim Descriptors: (See visual Illustration 6)

The verbatim descriptors included "She [nurse] was there with me, like family"; "She [nurse] was holding my legs massaging my feet and back"; "All the things she [nurse] did, she wasn't hesitating or didn't take long, I trusted her and it was very good"; "It helps with the pain and trust"; "She was the only nurse and knows what happened beginning to end"; "They [nurses] did what I needed"; "It was so beautiful, being calm, having her with you for all the time"; "She [nurse] was there quite alot because I have heard that some of those peoples [nurses] can be away one hour, so she was there."

Illustration 6

Trust



Observational Descriptors: (See visual Illustration 7)

The observational descriptors included nursing rituals such as orientation to the birthroom, assessment by performing Leopold's maneuvers, applying the electronic fetal monitor, IV therapy, documentation, and providing care practices such as massage, providing water, juices, yogurt, intramuscular medication administration, nitrous oxide gas inhalation, notifying anesthesia for epidural administration, and suggesting position changes.

Illustration 7

Ritualized Care

Patterns: (See visual Illustration 8)

These verbatim and observational descriptors led to identifiable care patterns that extended beyond the expected ritualized care as heard from the key informants and observed by the researcher and included special practices that helped the key informant:

1. Ritualized care by the nurse meant continuous presence with the key informant during birth.

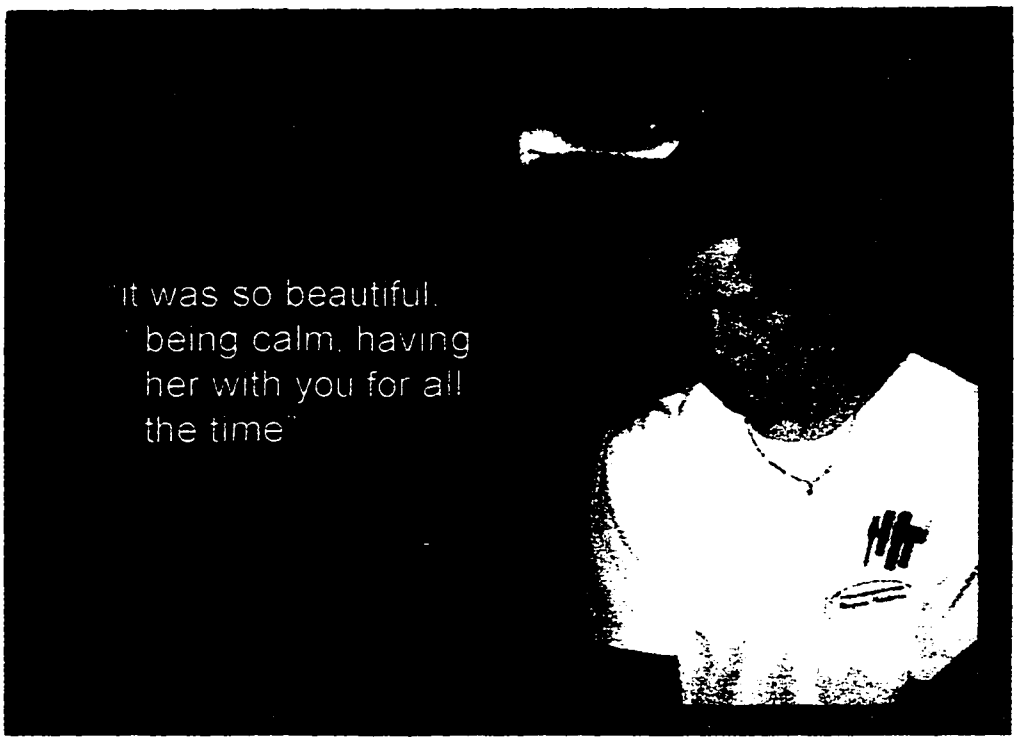
2. Ritualized care by the nurse meant building respect for and trust with the key informant during birth.

The researcher found that the ritualized care that was provided and the respect and trust that was instilled by the continual presence of the nurse were

particularly evident in the raw data. Beyond the usual nursing care rituals, nurses often remained in the birthrooms with the key informants to provide comfort measures and supportive practices that were expressed as most meaningful to the key informants.

Illustration 8

Continual Presence



Universal theme four: Professional care meanings and practices meant <u>anticipatory care with educational instruction and advocacy</u> for the key informant.

The nurses often relied on their professional expertise and experience in offering instruction on certain care practices that they knew would assist the key informants throughout their birth experiences. The nurses often taught the key informants how to use a variety of breathing patterns that would enable

them to cope with the pain or to bear down more effectively. They instructed the key informants on how to stand and perform pelvic rocking or lean over onto a beanbag to offset the pressure. They encouraged the key informants to change positions by assisting them to squat on a birth stool, to labor on their hands and knees, to rock in the rocking chair, etc.

This anticipatory care that has evolved from the nurses' education and experience, was identified as meaningful to the key informants as evidenced by such verbatim descriptors as, "Please try this and try that," "They tell what's new or what the easiest way to do things," and "I was glad she was able to do that." Two of the key informants believed that the nurses anticipated their needs by explaining not only how but why a certain care practice was important, "They explained what to do and why I cannot push yet, they explained things, not just say that do like this, don't do that."

One key informant expressed her appreciation for the nurse who advocated for her by suggesting possible choices, "The nurse is saying what we do, say what you have many possible choices" and more pointedly, "Her suggestions very helped me, please try this one and if I say that no, no, it doesn't feel good and I can't be here, she said there's not need to be, you can do what you want."

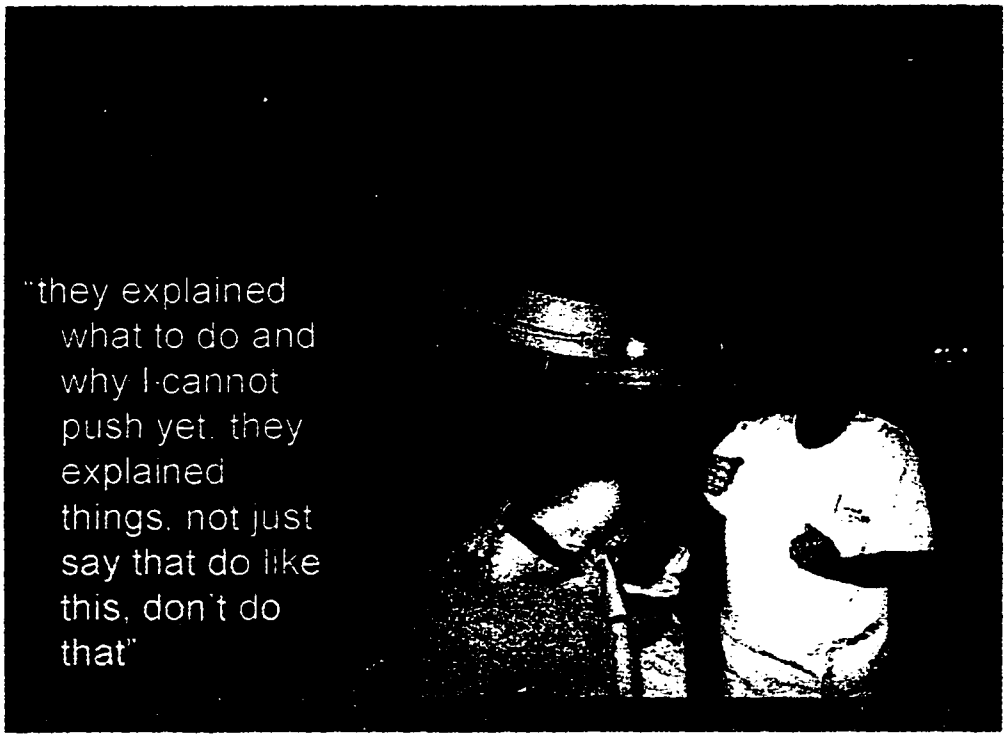
Verbatim Descriptors: (See visual Illustration 9)

The verbatim descriptors included "Please try this and try that"; "They tell what's new or what the easiest way to do things"; "I was glad she was able to do that"; "They explained what to do and why I cannot push yet, they explained

things, not just say that do like this, don't do that"; "The nurse is saying what we do, say what you have many possible choices"; "Her suggestions very helped me, please try this one and if I say that no, no, it doesn't feel good and I can't be here, she said there's not need to be, you can do what you want"; "I want nurse to speak me and say what happened and what do you want, that what do you think, or then I can to say something."

Illustration 9

Nurse Offering Instruction

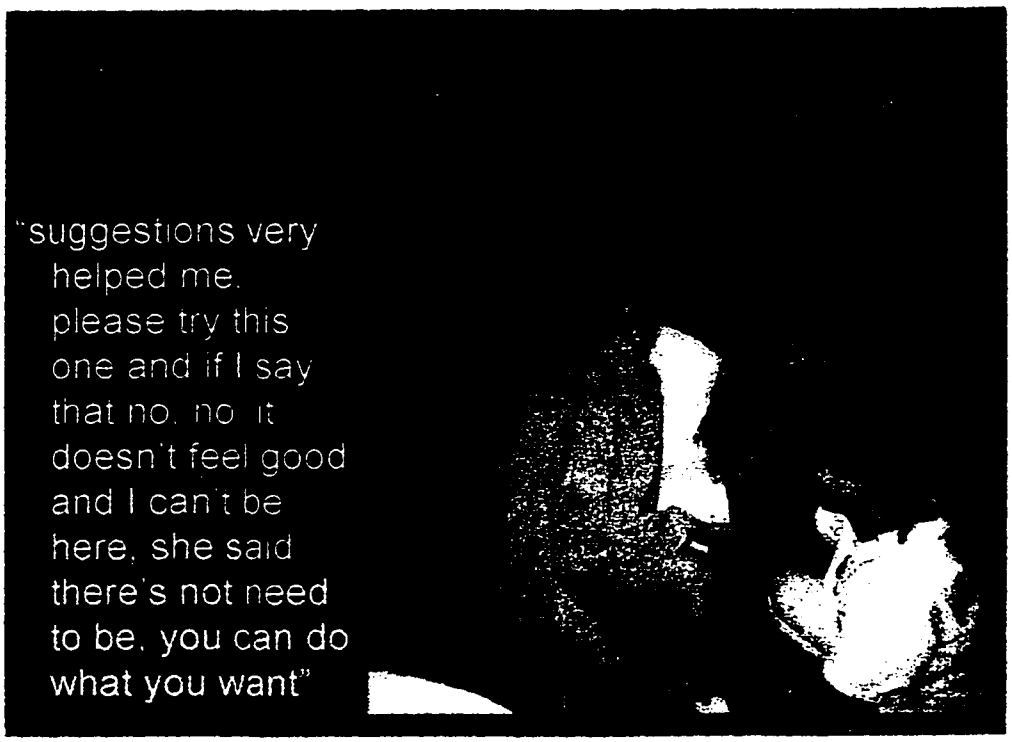


Observational Descriptors: (See visual Illustration 10)

The observational descriptors included offering instruction on breathing patterns or pushing techniques; teaching how to stand and perform pelvic rocking or leaning over onto a beanbag; encouraging to change positions to squat on a birth stool, to labor on their hands and knees or in the rocking chair.

Illustration 10

Nurse Offering Choices



Patterns: (See visual Illustration 11)

In analyzing these descriptors, patterns that were confirmed by the interviews became evident:

1. Anticipatory care meant offering instruction and explanations in predicting needs of the key informant during birth.

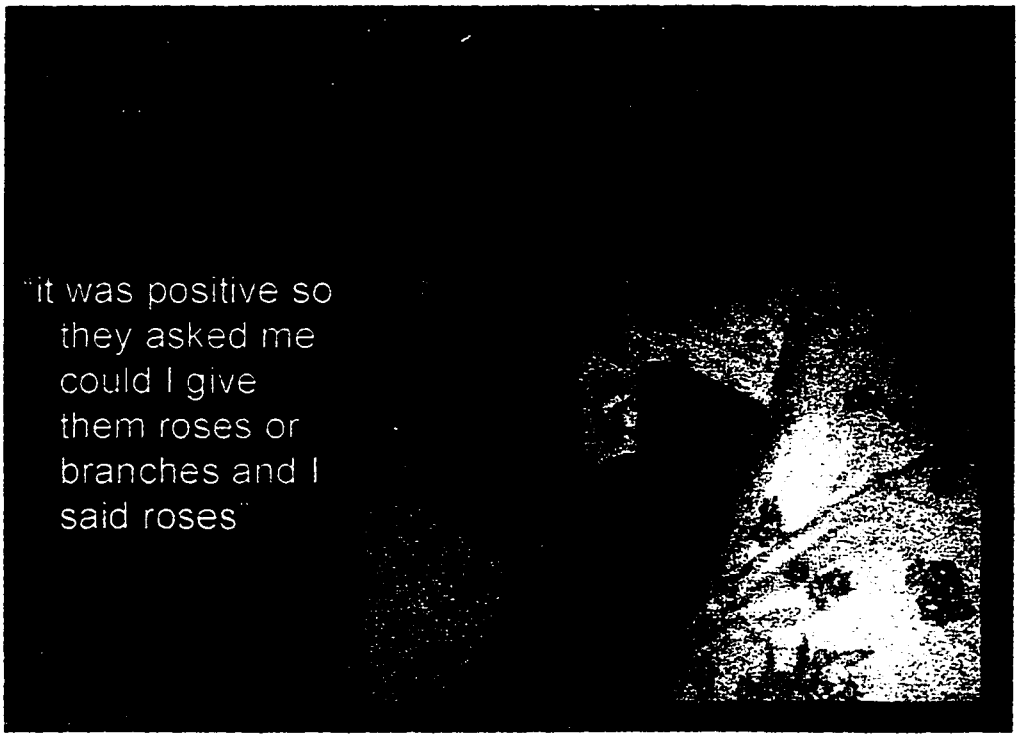
2. Anticipatory care meant advocating for the key informant by offering choices in meeting the needs of the key informant during birth.

It was evident that in anticipation of the key informants' needs, the nurses suggested choices and options for their care while providing explanations and rationale based on their education and experience. The pattern of advocacy became especially evident with an event that occurred concerning the use of

medication. After the nurse, requesting an order for pain medication, was denied, the nurse then argued that she had had 28 years of experience and knew the benefits of the medication for this particular situation. She was granted an order for the medication which enabled the key informant to relax and progress through labor more rapidly. The nurse then asked the key informant if she had had a positive birth experience. The key informant replied, "It was positive, so they asked me could I give them roses or branches and I said roses."

Illustration 11

Advocacy



Diverse Theme Five: Cultural care meant respect for differences in expression of <u>satisfaction</u> with the birth experience.

Eight of the ten key informants described their birth experiences as being

positive and satisfactory. Some expressed appreciation for the birth process to be a naturally occurring event. As one key informant stated, "I was scheduled for gel but am glad that started contractions anyway ... a natural birth day." Others seemed to acknowledge that minimal use of medication and/or intervention was an accomplishment for them in their capabilities to cope with the pain. "I think it is better for the baby to be without any medication when she or he borns." Another key informant supported this thought with, "If I manage without it, it would be nice." And finally, as one key informant commented, "I thought that the pain wouldn't be so hard but I feel it was so awesome that I quite tough."

Two of the key informants appeared to disagree or differ with the care provided for them during their birth experiences. One of the key informants stated that she was dissatisfied with her "rather mechanistic" care because of the multiple interventions and lack of explanations. All of the key informants appeared to trust the nurses and complacently obey their suggestions for care that may facilitate the labor or birth process. Another key informant expressed disappointment with her experience the following day, in that, she believed that "None of my wishes are [were] taken into account," and when her experience culminated into a Cesarean birth, she subtly claimed, "I don't think that the nurses or doctors failed but more like on that side." This meant that she believed that the professional care providers did not meet her expectations in facilitating her birth. They acted conservatively in their efforts to delay a possible Cesarean birth, letting her labor for a longer time than she believed

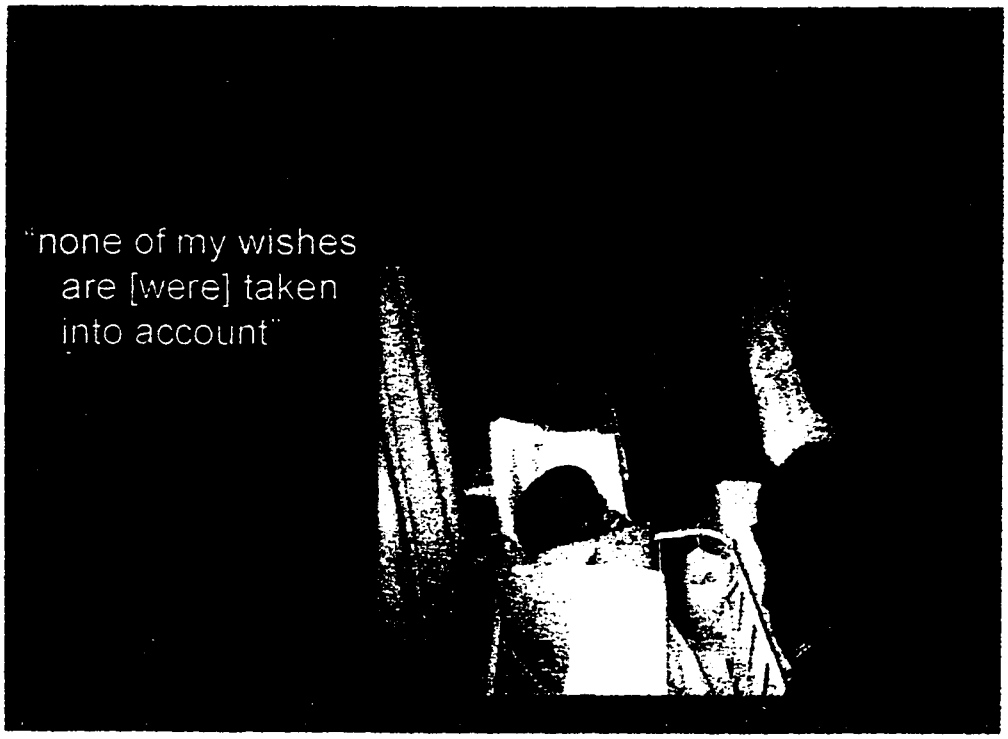
necessary.

Verbatim Descriptors: (see visual Illustration 12)

The verbatim descriptors included "None of my wishes are [were] taken into account"; "rather mechanistic"; "I don't think that the nurses or doctors failed but more like on that side."

Illustration 12

Disappointment



Observational Descriptors: (See visual Illustration 13)

Observational descriptors included facial expressions that displayed dissatisfaction or disappointment from expectations that were not recognized.

Illustration 13

Dissatisfaction

Patterns: (See visual Illustrations 14 and 15)

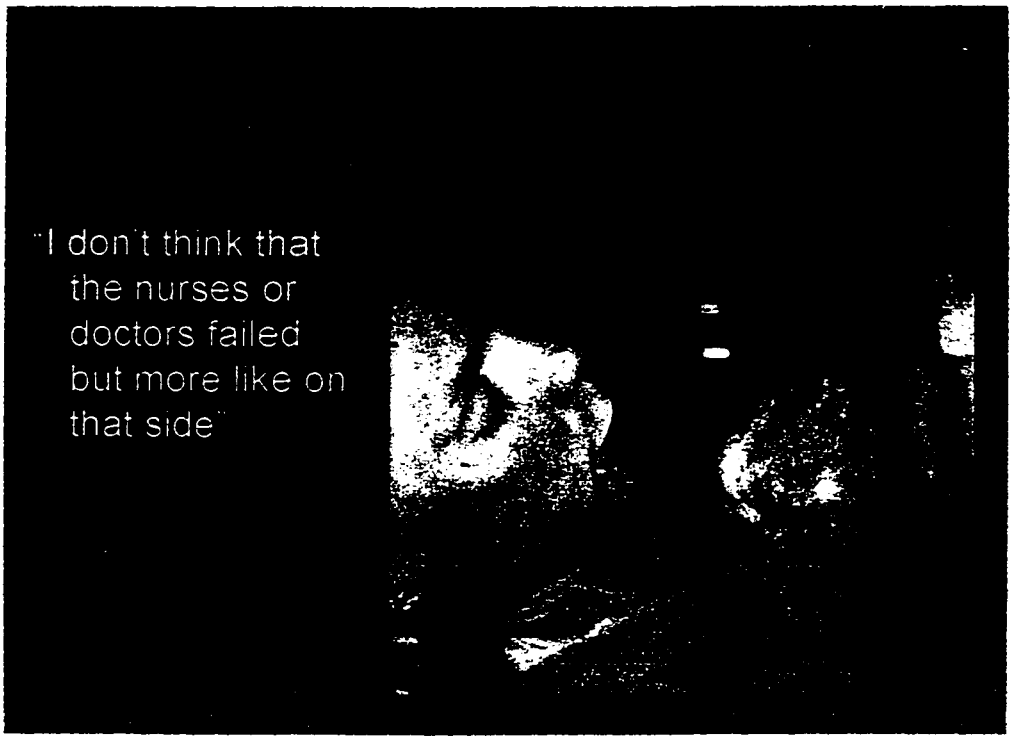
These verbatim and observational descriptors led to patterns that were confirmed by the interview data the following day. The derived patterns were determined from the recurrent descriptors and included

1. Culture care is recognition of expectations.

2. Culture care is expression of satisfaction with the birth experience.

Illustration 14

Unrecognized Expectations



Even though two of the key informants expressed dissatisfaction with their birth experiences, the other eight expressed satisfaction with their birth experiences such as satisfaction with the comfort care and protection provided by their generic caregivers and the ritualized care that provided continual presence and anticipatory care that offered instruction and choices by the nurses.

Illustration 15

Satisfaction

The major themes have been summarized below (see Table 2) to more clearly delineate their meanings and importance in terms of generic and professional care meanings and practices of Finnish women in birth.

Table 2

Major Themes of Generic and Professional Culture Care

Universal Theme 1	**Generic Care:**	**Comfort Care**
Universal Theme 2	**Generic Care:**	**Protective Care**
Universal Theme 3	**Professional Care:**	**Ritualized Care**
Universal Theme 4	**Professional Care:**	**Anticipatory Care**
Universal Theme 5	**Culture Care:**	**Satisfaction**

CHAPTER V

Discussion of Findings

The domain of inquiry for this transcultural nursing research study was generic and professional cultural care meanings and practices of Finnish women in birth using Leininger's theory of Culture Care Diversity and Universality. "To discover, know, and creatively use culturally based knowledge with its fullest meanings, expressions, symbols, and functions for healing and to promote or obtain well being (or health) with diverse peoples of the world" is the ultimate goal of a transcultural nurse (Leininger, 1991a, p. 73). Key to providing culturally congruent care, the goal of the theory, is an understanding of the influences of the cultural and social structure dimensions which are critical to identify and understand culture care. In addition, generic care and professional care meanings and practices were explored by the researcher from the emic perspective of the key informants.

The significance for nursing in achieving culturally congruent care was to examine care for the women in birth, from their perspective, and use that knowledge to generate ways in order to provide care in a competent and humanistic manner. Because birth is a universal event, the variability is often discovered in the culture itself, which was true of this study. After studying the culture of Finland for three years, the diversities of the Finnish culture were revealed as contributing to the fact that in 1994 Finland had the lowest infant mortality in the world at 4.7 deaths per thousand live births (Ministry of Social Affairs and Health, 1996, p. 8). Achieving culturally congruent care, based on

full and indepth understanding of the universalities and diversities, transcultural nurses can enable women to achieve a greater sense of well being worldwide.

Finn (1993), a transcultural nurse, used phenomenology to examine the meanings of generic and professional care and non-care as experienced by ten European-American women in birth in the United States. She explored the significance of worldview, cultural, and social structure factors as the basis of care. She found that childbirth beliefs and practices tend to vary with respect to the patterns of care during pregnancy, birth, and postpartum. Her findings revealed generic culture care modes whose essential characteristics included that the care modes were used over time in a naturalistic context; they were humanistically oriented; they were social, cultural, and non-technological; and they were familiar folk helpers. The professional culture care modes included essential characteristics which involved professional norms and standards, were scientifically oriented, emphasized technological skills, and were usually unfamiliar staff members in unfamiliar settings. She discovered that professional nurse care arises from "the integration and synthesis of generic care patterns into professional nurse care" (p. 282) which confirmed Leininger's theoretical position that professional nurse care is based upon culturally learned generic practices and are necessary to culturally appropriate care. The findings were important for birthing women in the United States and emphasized that women and their attendants should have similar, compatible beliefs associated with the birth process.

These findings were supported by the results of this research. Professional care included ritualized care to build respect and trust and anticipatory care with educational instruction and advocacy. The essential characteristics of Finn's professional culture care modes were similar to those found in this study. Generic care for this study included comfort care with physical presence and touch from family and protective care with empathy and trust from family. The essential characteristics of Finn's generic culture care modes were also similar to those found in this study. However, because the professional nurses were themselves Finnish, the researcher found that the nurses had been enculturated within their nursing and had combined generic and professional care practices.

In this transcultural nursing study, the ethnonursing research method was used in conjunction with the audiovisual method in order to explore and discover generic and professional care of Finnish women in birth. This research, based on knowledge from these two systems of generic and professional care, was humanistic care, in that it was healthy, beneficial, and congruent with the Finnish women's culture care values and needs. The generic care meanings and practices were discovered and were integrated with the nurses' professional modes of decisions and actions in order to achieve culturally congruent care that was highly compatible with Finnish women in birth. According to Leininger (1991a), these modes were 1) cultural care preservation/maintenance; 2) cultural care accommodation/negotiation; and/or 3) cultural care repatterning/restructuring. This researcher predicted

that selected aspects from both generic and professional care would be meaningful and culturally congruent nursing care and lead to a healthy, satisfying birth with less cultural conflicts and thus contribute to a woman's sense of well being.

Based on the above, it was the researcher's goal to discover the generic and professional cultural care meanings and practices, to explore cultural care dimensions influencing these meanings and practices, looking for the similarities and differences among informants to achieve culturally congruent care. To attain this goal, the ethnonursing and audiovisual research methods were used within Leininger's theory of Culture Care focusing on the discovery of emic knowledge, or the local, naturalistic, lay, or folk knowledge that was familiar and known to the women. Likewise, the researcher focused not only on emic knowledge, but also etic or outsider knowledge which provided a credible knowledge base for the achievement of culturally congruent care. The etic, or outsider's views were considered with the emic, or generic folk knowledge, in order to obtain an indepth and accurate perspective of generic and professional care that would guide transcultural nursing practices.

The period of time spent in studying the Finnish culture, the intense depth in collecting data during the birth experiences of the key informants, and the use of the ethnonursing and audiovisual methods assisted the researcher in meeting the qualitative criteria of credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability. The field notes from the observation-participation-reflections of each of the birth experiences assisted

the researcher to sequence the photographs in story-board format creating an indepth visual representation of the data. Data were analyzed using the four phases of the Leininger Data Analysis Model. Patterns discovered from the raw data, the verbatim and observational descriptors, and photographs, revealed generic and professional care practices from which the meanings were derived. The generic and professional care meanings and practices were examined in relation to the worldview, cultural, and social structure dimensions of the Finnish culture which lead to overall themes that were confirmed in the analysis of the data.

Two themes were identified from the generic care perspective, namely, care provided to the women by significant others during each of their birth experiences. Descriptors of the verbatim and observational raw data lead to patterns from which the themes of comfort care and protective care were derived. Two themes were also identified in terms of the professional care which were ritualized care and anticipatory care. From the emic perspective of the key informants, descriptors and patterns indicated these themes to be evident. The observational descriptors and patterns of the professional care practices were confirmed with the emic views by key informants during retrospective interviews in terms of what they valued or saw as contributing to the meanings of the generic and professional care. Creative thought and analysis allowed the researcher to synthesize the small units of generic and professional behaviors or care practices into patterns to obtain a comprehensive, holistic view of the data as themes. Using the confirmed

themes to develop transcultural caring modes with decisions and actions concludes the analysis of ethnonursing data. This last phase focused on developing three predicted modes of nursing care that were based on the verbatim, observational, and photographic descriptors and patterns. Throughout the analysis of the qualitative data, the criteria of credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability were used to support or refute the findings.

Major Findings

The major themes that were abstracted from the extensive and intensive qualitative data analysis included the following:

Universal theme one: Generic care meanings and practices meant comfort care with physical presence and touch from family.

Universal theme two: Generic care meanings and practices meant protective care with empathy and trust from family.

Universal theme three: Professional care meanings and practices meant ritualized care to build respect and trust with the key informant.

Universal theme four: Professional care meanings and practices meant anticipatory care with educational instruction and advocacy for the key informant.

Diverse theme five: Cultural care meant respect for differences in expression of satisfaction with the birth experience.

Action Modes for Nursing Care

The theory of Culture Care Diversity and Universality has as its goal "to

provide culturally congruent and competent nursing care that would lead to client or group health and well-being" (Leininger, 1997, p.97). This goal was the underlying intent of the researcher in exploring and discovering generic and professional care meanings and practices for Finnish women in birth. The purpose of Culture Care theory was to discover human care diversities and universalities and to use this knowledge to provide culturally congruent nursing care as a means to achieving well being (Leininger, 1997). The researcher predicted that the discovery of generic care meanings and practices would provide valuable knowledge about culture care in Finland. Professional care, as observed by the researcher and confirmed by the key informants, when combined with generic care knowledge, was predicted to provide insight into how the goal of the theory, cultural congruence, could be realized. Three ways in which culturally congruent care could be provided were first envisioned by Leininger (1991a, 1997): 1) culture care preservation and/or maintenance, 2) culture care accommodation and/or negotiation, and 3) culture care restructuring and/or repatterning. Leininger predicted that if nurses studied these three modes systematically in relation to the worldview, generic and professional care, and cultural and social structure factors of a particular culture, they could creatively and appropriately make responsible decisions and take actions that could lead to culturally congruent nursing care, thereby promoting health and well being of the people involved (Leininger, 1997).

Culture Care Preservation and/or Maintenance

Transcultural nurses who have culture care knowledge are expected to plan

care or make decisions with respect to preserving or maintaining certain care meanings and practices. The thematic findings of this study would enable nurses caring for Finnish women in birth to preserve or maintain generic care meanings and practices bearing on comfort care and protective care. For example, the Finnish women expressed the value of and need for having a care provider offering presence, touch, massage throughout their birth experiences. If such an individual was not able to attend to the woman, the nurse could offer the same comfort and protective care which would be expressed by remaining with the woman throughout the birth experience. In the same way, nurses could plan their care with respect to the laboring woman's emotional needs. Having a nurse offering empathy, trust, and assurance of safety was found to be valued by the Finnish women.

Professional care with the nurses included generic care that was integrated into their practices. Ritualized care had integrated generic and professional care; however, generic care was not recognized by the nurses. The home or folk practices from the nurses was evident and based on professional education and experience with women in birth. Performing nursing rituals of maintaining continuous presence built trust with the woman which was held to be meaningful to the Finnish women. In addition, the nurses' offering of information and explanations of procedures, progress in labor, etc., and allowing the women choices in anticipation of their needs during their birth experiences was important. Demonstrating advocacy for the women as a caring construct encouraged a humanistic birth experience that was respectful

of their values.

In a study by Hemminki, Kojo-Austin, Malin, and Koponen (1992), birth interventions by 25 midwives among 2135 births in a Finnish hospital, were examined. They found that the skills, attitudes, and routines of midwives may explain the variation found in birth interventions. In this particular study, as is customary throughout Europe, midwives care for women throughout their labors and deliveries. This is in contrast to professional nurses in the United States who manage women's birth experiences and the physician or midwife only attends the delivery. As stated by these researchers, "All countries do not have midwives in their labor wards, but other auxiliary staff, i.e., nurses, may have a similar role" (p.84). Hemminki et al. (1992) found that the midwives may influence the rate of Cesarean sections as a birth intervention, in three ways, namely, how nurses who take care of the women affect their progress in labor and the attitudes and wishes of the women, how quickly nurses call the physician if a problem is suspected and what information is conveyed to the physician and the women, and how actively the nurses intervene with pain-relief measures or augmentation of labors. Many birth interventions were largely related to the professional care provided to the women in birth. Decisions or choices made by the women were not studied.

In another hospital study in Finland, Hemminki, Virta, Koponen, Malin, Kojo-Austin, and Tuimala (1990) examined midwives' attitudes on social support during labor and factors impeding or facilitating progress in labor. The researchers found that of 21 midwives included in the study, more than one-

half believed that they spent over half of their time with the laboring women. They held that concerning the midwife's presence during labor, more felt that it was not important; only five of the 21 considered the midwife's constant presence important, and nine not at all important. For laboring women, their progress improved if encouraged to sit in a rocking chair and given pain relief.

Most of these research findings were supported in this research, especially in terms of professional care that included repositioning the women, i.e., encouraging them to sit in a rocking chair, sit on a birthing stool, stand and lean over onto a beanbag chair, kneel on hands and knees on the bed, etc. However, these etic view findings were not supported in terms of the emic view findings of key informants in this research. Key informants for this study highly valued the presence of the nurse. Such verbatim descriptors as, "She [nurse] was there with me, like family" and "She was only nurse and knows what happened beginning to end", confirmed this conclusion. As another key informant stated, "She [nurse] was there quite alot because I have heard that some of those peoples can be away one hour, so she was there." Observational descriptors revealed that many of the key informants highly respected the Finnish health care system and opinions of the professional care providers. As revealed earlier, one key informant even left her career position in another country to go home to Finland to give birth.

Nurses who demonstrate care, maintain and preserve the women's kinship and family relationships. For example, planning care that included family members, siblings, etc. to attend the birth and/or visit soon afterwards during

the hospital stay is caring, in that their need to be together during this important life event is respected. Since health care in Finland is a social, political, and economic right with concomitant responsibilities, it would be important for nurses to ensure these rights are upheld in their caring actions and decisions. Social equity and universal access to health care upholds the culture's commitment to improving both the standard and distribution of health care. Nurses could continue to act politically to eradicate the disparities in health between different socio-economic groups and preserve the universal and comprehensive health services that their culture values.

Culture Care Accommodation and/or Negotiation

Opportunities occurred during the women's birth experiences that necessitated that the professional caregivers accommodate care practices of generic comfort and protective care. Finnish nurses performed care rituals incorporating the generic caregivers (husbands) into teaching and practices. Finnish nurses taught massage and the application of pressure to the husbands in order to accommodate the women's needs for comfort. In two of the birth experiences, Finnish nurses offered care to the women whose generic caregivers (husbands or family members) were not present. The nurse's care was described by these women as valuable in meeting their needs for comfort and protective care.

Failure to negotiate or accommodate care according to Finnish women's values could lead to cultural conflict and nontherapeutic outcomes. Cultural care accommodation and/or negotiation involving respect for the Finnish

cultural and social structure dimensions such as the educational, political, economic, and health care systems would be imperative to provide beneficial or satisfying care to the women that would contribute to well being.

Culture Care Repatterning and/or Restructuring

Another nursing care modality requiring nurses to have culture care knowledge is repatterning and/or restructuring. In this study, the nurses were found to possess extensive culture care knowledge in order to provide culturally congruent care. However for non-Finnish nurses, this mode requires that they be knowledgeable about the Finnish culture care lifeways. Nurses need to examine their care meanings and practices that would facilitate satisfaction for Finnish womens' birth experiences. For example, nurses would need to creatively design their care practices in order to include generic caregivers, i.e. husbands, significant others, family members, etc. for comfort and protective care during this important life event. Their care would need to demonstrate respect for their beliefs regarding Finland and the various cultural and social structure dimensions that influence Finnish women's values.

Both generic and professional knowledge are important to consider in planning nursing care goals and actions. For example, the nurse, with a sound knowledge base of the Finnish culture, would understand that Finnish women need to use the sauna for a means to promote relaxation and cleansing during pregnancy. Despite the recommendations to avoid extremely high temperatures during pregnancy, the nurse could suggest that the woman restructure her daily ritual by sitting on the lower level of the sauna where

temperatures are less extreme and for shorter periods of time. Cultural care knowledge and practices for Finnish women need to be repatterned to provide safe, cultural congruent care, respectful of Finnish lifeways.

Some care institutions need to restructure and repattern their health care in order to provide care that is meaningful and beneficial, especially to the women seeking care during their birth experiences. Finnish women expect care that is based on social equity and care that is universal for all. Educational, political, and economic dimensions of the Finnish culture support the health care system. Because of their past history of domination and turmoil, Finnish women are proud of their country's independence. They show their pride by being obedient and dutiful to individuals in authority, i.e. professional caregivers. Finnish women hold kinship and family relationships in high regard. For example, when Finnish women decide to plan for a family, they expect care that includes their significant others. They expect free prenatal care throughout their pregnancies which is typical of the socialized health care system and which reflects the Finnish culture's value of universal health care. They expect to prepare for their birth experiences by participating in classes, tours, by reading resource materials which reflects the Finnish culture's value of education. They expect a free and accessible hospital birth experience. They expect to be supported economically and politically in their decision to remain home with their young children for a guaranteed 10-month leave. They expect government subsidized day care with a monthly child allowance and full educational benefits once they choose to return to work.

Many health care systems throughout the world are different and would not offer these care practices. In the United States, indepth reexamination of priorities in health care that reflect the values of social equity and kinship would be necessary in order to achieve holistic, culturally congruent care to benefit all individuals. In addition, nursing care in the United States could follow the Finnish model of nurse midwifery care, in that professional care, which includes ritualized care integrated with generic care, could build respect and trust. Anticipatory care with educational instruction and advocacy, could lead to a greater sense of well being for women in birth. These findings advance transcultural nursing knowledge and with the holistic, naturalistic care meanings and practices discovered, contribute to reduced perinatal mortality statistics in the United States.

Strengths and Limitations of the Study

This first transcultural nursing research study in Finland focusing on women in birth, explored generic and professional care meanings and practices and had important discoveries. This study centered on indepth knowledge of selected key informants giving birth in a large urban hospital in Finland. The study of generic and professional care practices was essential to arrive at culture specific care to facilitate holistic, culturally congruent care. The findings of this study are useful to discover care meanings and practices in this Finnish urban context and would be most useful for nurses providing care to women in birth in other similar contexts. A similar study was conducted by the researcher in the United States in a similar urban context so that experience with the

ethnonursing and audiovisual methods and full knowledge of the theory could be employed in Finland. Further research conducted in the rural Finnish context or environment is recommended to contrast urban and rural care meanings and practices.

The researcher's length of stay in Finland was limited; however, the researcher did intensive study during the time in the country. In addition, the researcher had studied the culture for approximately two years prior to conducting the study. This time helped to facilitate entry, remain in the country to learn about the culture directly, and to conduct intense data collection. The participant-observation-reflection and other enablers, specific interviews, and photographs were used with all informants in the hospital context. The interviews were conducted retrospectively so that the informants could reflect on their birth experiences and bring forth the emic perspective of their care meanings and practices. The observation-participation-reflection enabler and the ethnonursing field notes were shared with each of the key informants so that indepth meanings could be documented and findings confirmed. Due to the unavailability of immediate photo processing and developing resources, the photographic sharing of the observational descriptors to allow for further significance and meanings during the retrospective interviews was not possible. However, the key informants each received duplicate copies of all photographs as a benefit for participation in the study and were given the opportunity to select the most significant photographs for use in the study. Once the photographic story-boards for each of the birth experiences were

constructed, meanings and interpretations were clarified visually and later confirmed through written birth stories by the key informants. Open-ended questions relevant to the cultural and social structure dimensions of the Sunrise Model were utilized to lend credibility to universalities and diversities discovered. The researcher, with 21 years of professional and clinical experience with women in birth, as previously stated, had conducted a similar study in the United States which helped enormously to facilitate this ethnonursing study within Leininger's theory in another country.

The researcher's understanding of the Finnish language was limited but the study was conducted with modest language use. More extensive knowledge of the language may have helped with indepth meanings and subtle discoveries. Even though each of the key and general informants could speak English, specific interpretations or explanations may have been misunderstood. Researchers conducting a study on participants with English as a second language recommend that the use of personal contacts (with correct pronunciation of their names), the use of a semi/unstructured interviews with open-ended questions and probes, the use of simple grammatical constructions, the use of audiotaping, attending to nonverbal behaviors, and that the use of field notes to record nonverbal behaviors and context would enable the researcher to increase understanding and confirm meanings (Marshall & While, 1994). The researcher asked open-ended questions using simple grammar and probed with further questions to increase understanding of the verified verbatim. The researcher listened carefully during the interviews

taking field notes and to the recorded audio tapes several times in order to confirm the verbatim. Data were also confirmed with the use of written birth stories. These narrative accounts, written by the women themselves, were limited to only two stories. Because all of the key informants had selected English as their second language and were willing to participate, the researcher's beliefs that misinterpretation of data due to language barriers was minimal. In general, this research was an indepth study of selected Finnish women with detailed observation-participation-reflections and careful analysis of care meanings and practices during their birth experiences. Such similar qualitative studies are needed in the United States and all world cultures.

Recommendations for Future Research

Health care issues are foremost priorities for policy and legislative agendas in today's health care crisis in the United States. Cost, access, and quality of health care have become the most compelling reasons for driving policy change (Olds, 1996). Health care reform is seeking to address the out-of-control health care costs. Access to health care contributes to the crisis as there are as many as "37 million uninsured people in the United States and a debatable number underinsured" (p. 9). Nevertheless, issues of cost and access at times overshadow the concern about quality of health care. Outcomes of care in the United States are usually not determined but considered essential if there is to be comprehensive health reform. Instead, our outcome-based system is largely based on economic gains and to reduce health care costs - not quality care for our multicultural society.

The Coalition for Improving Maternity Services (CIMS) is a coalition of individuals and national organizations in the United States who have expressed concern for the care and well being of mothers, babies, and families. It has as its mission,

> to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs. This evidence-based mother-, baby-, and family-friendly model focuses on prevention and wellness as the alternatives to high-cost screening, diagnosis, and treatment programs (CIMS, 1996).

The preamble states, whereas:

- In spite of spending far more money per capita on maternity and newborn care that any other country, the United States falls behind most industrialized countries in perinatal morbidity and mortality, and maternal mortality is four times greater for African-American women that for Euro-American women;
- Midwives attend the vast majority of births in those industrialized countries with the best perinatal outcomes, yet in the United States midwives are the principal attendants at only a small percentage of births;
- Current maternity and newborn practices that contribute to high costs and inferior outcomes include the inappropriate application of technology and routine procedures that are not based on scientific evidence;
- Increased dependence on technology has diminished confidence in women's innate ability to give birth without intervention;
- The integrity of the mother-child relationship, which begins in pregnancy, is compromised by the obstetrical treatment of mother and baby as if they were separate units with conflicting needs;
- Although breastfeeding has been scientifically shown to provide optimum health, nutritional, and developmental benefits to newborns and their mothers, only a fraction of United States mothers are fully breastfeeding their babies by the age of six weeks.

The current health care system in the United States does not provide equal access to health care resources for women of diverse cultures nor does it

focus on care phenomena. Changing the health care system in the United States requires transcultural knowledge and competencies. Primary health care services should be the basis upon which all other services are built, similar to Finland's health care model. Today, the system in the United States is the opposite with emphasis on high technology; 75% of third party reimbursement is for hospital-based acute care. Furthermore, 5% of the population spends 58% of the American health care resources (ANA, 1993). To change the health care system in the United States to a transcultural health system, all cultural groups should have access to primary health care that is congruent with cultural values and beliefs. If culturally congruent care within our multicultural society is to be a reality, the following recommendations need to be considered:

1. Professional care needs to move beyond the medical model of care practices and the traditional Western medical beliefs to develop a transcultural knowledge base that directs care to be holistic and humanistic for women of all cultures. This includes a focus on health promotion and prevention for all, a focus that Finland has clearly chosen and found success. Following the European model of midwifery care by encouraging the use of midwives to provide continuous care throughout women's birth experiences from beginning to end would assist in achieving this focus. This emerging shift in health care presents a significant opportunity for nursing in the United States to contribute to health care reform through transcultural nursing research that provides evidence for changes that address cost, access, and quality issues.

2. Generic care needs to be explored, discovered, and respected for its cultural significance for contributing to the health and well being for all women. Recognition of birth as a natural, healthy, and highly cultural experience with deeply embedded values and beliefs is essential in order to provide care for women in a culturally congruent way. Women need to be respected for their capabilities and inherent wisdom that is necessary for birth. Acknowledgment of the importance of generic care meanings and practices with a transcultural nursing focus could greatly revolutionize health care to women.

According to Wagner (1994), most countries are following the World Health Organization's lead in formulating health policy that emphasizes primary health care in local or rural settings as opposed to specialized care in hospitals. However, "ironically, in these same countries prenatal care is moving in the opposite direction, from midwife or general practitioner to obstetrical specialist" (p.74). A study in Finland documented this trend:

> Traditionally, the Finnish prenatal care system has been based on special maternity centres outside hospitals. In recent years, however, the use of hospital outpatient clinics has increased. The purpose of this study was to describe the use of the clinics and to see whether clinics serve as an addition or as an alternative to maternity centres. [We found that] the content of care and means of care delivery differ between clinics and maternity centres. Clinics are technologically and provider-oriented without continuity of care. Clinics are not just referral centres for high-risk mothers; at least half of pregnant women visit them. Hospital clinic care now seems to replace care in maternity centres: (Hemminki, et al., 1990, p. 221).

Today, the field of transcultural nursing is established as an essential, legitimate, and significant area of formal study and practice. Transcultural concepts, principles, theories, and findings are being used to change nursing care practices to preserve/maintain, accommodate/negotiate, or

repattern/restructure nursing care decisions and actions. Transcultural nurses can use their knowledge to reverse this trend toward highly specialized and technical care and work toward providing holistic and humanistic care from a transcultural perspective. Based on this research, the efforts of the World Health Organization to move health care to the naturalistic, rural setting need to be supported. The findings of generic and professional care meanings and practices for Finnish women in birth can have a profound effect on the care of women in our multicultural society in the United States and throughout the world.

Conclusion

This transcultural nursing study, conceptualized within Leininger's Theory of Culture Care (Leininger, 1985, 1991, 1995) was the first to systematically examine the generic and professional care meanings and practices of Finnish women in birth. The theoretical framework provided a holistic guide to discover how the worldview, cultural, and social structure dimensions of the Finnish culture influenced the care meanings and practices that contribute to the well being of the Finnish women. Since birth is a universal, cultural, and holistic process worldwide, the diversities were discovered in the cultural and social structure dimensions. These diversities could have easily been overlooked if it were not for the holistic approach of the Culture Care theory. The research findings substantiated the tenets of the theory, while providing the foundation for the discovery of the universalities and diversities of care meanings and practices. This discovery of Finnish transcultural knowledge, especially generic

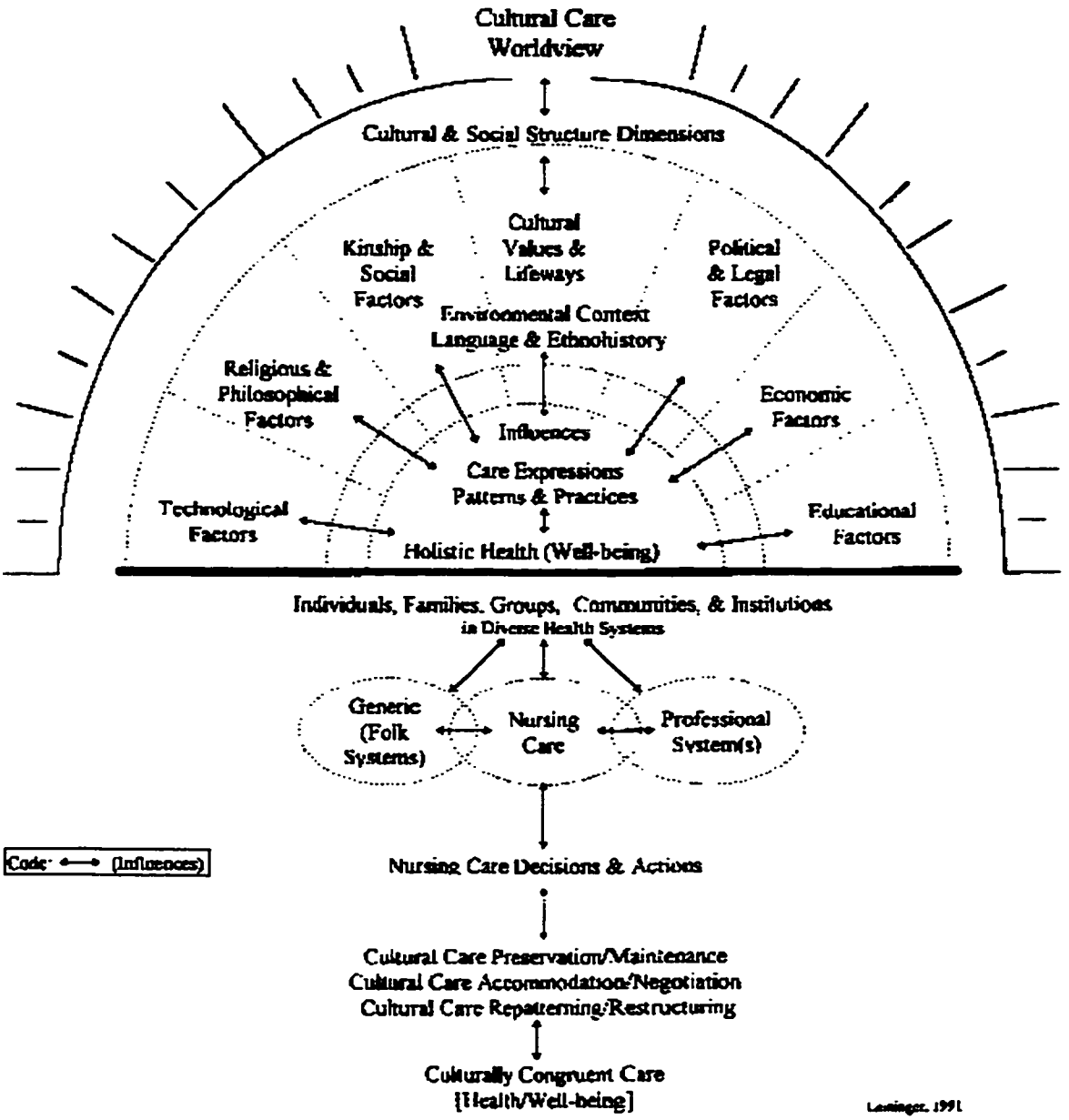
and professional care, needs to be used to guide nursing in general and most importantly, the future of transcultural nursing practice and research into issues facing health care reform in the United States.

Four universal themes and one diverse theme discovered through the qualitative ethnonursing and audiovisual methods supported Leininger's prediction that themes would be discovered from transcultural studies guided by this framework. Two themes identified from the generic care, comfort care and protective care, and two themes identified from the professional care, ritualized care and anticipatory care, supported the researcher's prediction that birth and the care meanings and practices surrounding the birth process are culturally constituted. The professional care specifically revealed fully integrated generic care meanings and practices because of the nurse's deeply imbedded knowledge of the Finnish culture. The remaining theme of diversity that was identified as cultural care satisfaction brought to light the influence that the cultural and social structure dimensions had on the birth experiences of the women.

Throughout this transcultural study, the ethnonursing and audiovisual methods, guided by the theory of Culture Care, helped the researcher to analyze the findings that would contribute to transcultural nursing's body of knowledge and assist nurses to provide culturally congruent care to women in birth throughout the world. In this way, care for women in birth would be holistically and humanistically understood to contribute to their well being. For this reason, this research is crucial to the health of women worldwide.

Appendix A

Leininger's Sunrise Model to Depict the Theory of Cultural Care Diversity and Universality



Note. From Culture care diversity and universality: A theory of nursing (p. 43), by M. Leininger, 1991. New York: National League for Nursing. Reprinted with permission.

Appendix B

Informed Consent Form

Principal Investigator: Judith K. Lamp, RN, MS, FACCE
h: 419-734-6282
w: 419-381-5800

Introduction: You are being asked to participate in a research study of cultural care meanings practices of women in birth. This is a qualitative study in which the purpose is to discover the culturally based care meanings and practices of women in birth so that nurses could provide care that could contribute to their health and well being. You were selected as one of ten possible participants in this study because you: 1) identify yourself as Finnish, 2) are pregnant with multiparity status, 3) have an expected date of delivery within the specified time frame, 4) plan to deliver at the Maternity Clinic, and 5) volunteer to participate in the study.

Procedure: If you decide to participate, your labor and delivery experience will be recorded by the nurse researcher with written notes and photographic recording. All nursing care and care provided by others will remain the same. The researcher will remain with you throughout the duration of your experience, from admission through delivery, until your recovery period (about 1 hour after birth) is complete. The researcher will then arrange to interview with you prior to discharge from the hospital and then at home to discuss the care practices and their meanings.

Risks: There are no reasonable, foreseeable risks, discomforts, or inconveniences to you other than the presence of the nurse researcher during this momentous event.

Benefits: The benefits to be derived from this study are primarily for nursing professionals that provide care during the birth experiences to women of diverse cultures. I cannot and do not guarantee or promise that you will receive any benefits from this study. If you decide to participate in this study, you will be compensated by receiving a photographic record of your birth experience in the form of pictures at no expense to you.

Confidentiality: If you indicate your willingness to participate in this study by signing this document, I plan to disclose the data only, no names, to my Dissertation Committee Chair, Dr. M. Leininger, College of Nursing, Wayne State University, in a coded format for the purpose of data analysis. Any information that is obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your permission. The photographic record in the form of slides will be utilized only with your permission to present research information at future nursing conferences. Only I the researcher and my Chair will have access to the data. No names will be disclosed at any time.

There will be no additional cost to you because of your participation.

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with Helsinki University Central Hospital or its personnel. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty.

If you should decide to withdraw, you should contact Judith K. Lamp to formally terminate from this study. Anticipated circumstances under which you may be terminated from the study are only those that prevent me from observing your birth experience, at which time I would notify you immediately.

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think this over.

YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTICIPATE IN THIS STUDY. YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION PROVIDED ABOVE, HAVE HAD ALL YOUR QUESTIONS ANSWERED, AND HAVE DECIDED TO PARTICIPATE.

YOU WILL RECEIVE A SIGNED COPY OF THIS FORM.
Date _____
Time _____a.m._____p.m.

_____
Name of Participant (please print)

_____
Signature of Participant

_____
Witness/Legal Guardian

_____
Signature of Investigator, Judith K. Lamp

YOU WILL BE GIVEN A COPY OF THIS SIGNED CONSENT FORM TO KEEP.

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research subject or research-related injuries, please feel free to contact Professor and Chairman, Department of Obstetrics and Gynecology, Dr. Markku Seppala at 358 0 471 2800 or Wayne State University Chairman, Dr. Peter Lichtenberg, Ph.D. at 313-577-1628 or Dr. Douglas Wilkerson, Associate Vice-President for Research, Medical College of Ohio at 419-381-4251.

Appendix C

Inquiry Enabler for Women in Birth

Inquiry Approach: This enabler has been developed to specifically tease out ideas related to the domain of inquiry focused on generic and professional cultural care of Finnish women in birth. This enabler will be used as an open inquiry guide to discover the care meanings and practices for Finnish women during and after their birth experiences. Open frames and scenarios will be used when discussing their experiences with each of the women. The key informants will be encouraged to "tell their story" or their experience of birth in their own way which will be fully documented. This guide will be used by the researcher only and will not be given to the key or general informants.

Opening Statement: I am eager to learn from you about your birth experience and appreciate your willingness to share your experience. Now that you have experienced the birth of this child, I am interested in knowing more about the care that was provided for you during your labor and birth for this child as well as previous children. You were cared for by nurses and by other individuals or support persons prior to your birth and those that accompanied you during your birth experiences. I would like you to tell me about your care experiences, their meanings, and how they helped you. Your comments will not be identifiable but will be kept in confidence to facilitate open sharing.

I. Ethnodemographics

Name _____

Age _____ EDC _____ G ____ P ____ P ____ A ____ L ____

Place of Birth _____ Year _____

Date of Delivery _____ Sex _____ Name _____

Generic Caregivers _____

Professional Caregivers _____

II. Sunrise Model Dimensions

1. I am interested in knowing more about you and your Finnish cultural lifeways. Tell me about your community and your life. How was your childhood and growing up in your Finnish community? How do you as a Finnish woman see your world?

2. I would like to know more about your education. Tell me about your schools

that you attended, what you like or dislike about learning, about teachers.
3. Let us now talk about economic factors in your life. Tell me about your sources of income, your available resources for your family, your baby.

4. I would like to know about political or legal factors that have influenced your life, your family, your baby.

5. Tell me about the technology in your life. How has the use of technology affected your life, your family, your baby.

6. Let's talk about your religion and philosophy of life. Your religion is . . . The best way to describe your philosophy of life is . . .

7. I would like to know about your present family. Tell me about your children. When and where were they born? I would like to know more about your past pregnancies and birth experiences. Tell me about them, describe your labor and birth experiences and the care that you received. Tell me about their father. When and where was he born? Describe the rest of your family.

8. I would like to discuss your values and lifeways. You think that you most highly value . . . What other kinds of things are important to you in your life? Describe your life, your patterns of daily life.

9. What about your ethnohistory, your past that has influenced your life, your family, your baby.

10. Your language is very beautiful and unique. Tell me how your language has affected your life, your family, your baby.

11. Describe your environment in which you live, in which you have given birth. How has this affected your life, your family, your baby.

12. I would like to know more about this pregnancy and birth experience. Tell me about your prenatal care, any formal or informal kinds of educational preparation for birth, any decisions planned regarding choices about:

birth site:

care-provider/s:

<u>labor-stage 1:</u>

<u>labor-stage 2:</u>

<u>labor-stage 3:</u>

labor-stage 4:

III. Birthing Experience Inquiry Areas

In this section, the researcher will mainly address generic and professional care practices of women in birth. The terms "generic" and "professional" will be clarified with the informants.

Part 1

1. Tell me about your birth experience with this baby.

2. Tell me about your previous birth experience/s.

3. Describe how this birth experience and your previous ones are different.

4. Describe how this birth experience and your previous ones are the same.

5. What kinds of actions or behaviors did the nurses do to care for you during your birth experience/s?

6. What kinds of actions or behaviors did your support person/s do to care for you during your birth experience/s?

7. Share with me how the nurse's actions or behaviors were helpful to you during labor? during birth?
8. Share with me how your support person/s actions or behaviors were helpful to you during labor? during birth?

9. I am interested in knowing how you feel about your present birth experience, your past birth experiences?

10. If you could change anything about your past or present birth experiences, describe what that would be.

11. Is there anything or anyone that could have helped you any differently with your birthing experiences? If so, what or who could that be?

12. Is there anything else that you wish to tell me about your past or present birth experiences?

(Lamp, J., 1997)

Kysymyksia Synnyttaneille Aideille

Olen hyvin kiitollinen siita, etta annoit minulle mahdollisuuden olla mukana synnytyskokemuksessasi. Nyt kun olet synnyttanyt, tahtoisin tietaa lisaa siita hoidosta ja huolenpidosta jota sinulle annettiin taman synnytyksen, kuten mahdollisesti myos aiempien synnytyksiesi aikana. Sinusta pitivat huolta niin sairaanhoitajat kuten myos mahdolliset tukihenkilot (aviomies, ystava, ym.) jotka seurasivat sinua lapi synnytyskokemuksesi. Tahtoisin sinun kertovan huolenpidosta jota sait osaksesi.

1. Kerro tasta synnytyskokemuksestasi.

2. Kerro mahdollisista aiemmista synnytyskokemuksistasi.

3. Selvita miten tamankertainen synnytyksesi erosi aiemmista.

4. Selvita mita yhteista oli tamankertaisella ja aiemmilla synnytyskokemuksillasi.

5. Mita sairaanhoitajasi teki tai sanoi pitaakseen sinusta huolta synnytyskokemuksesi aikana?

6. Mita tukihenkiosi teki tai sanoi pitaakseen sinusta huolta synnytyskokemuksesi aikana?

7. Kerro miten/miksi se, mita sairaanhoitajasi teki tai sanoi auttoi sinua lapi synnytyskokemuksesi?

8. Kerro miten/miksi juuri se mita tukihenkilosi teki tai sanoi, auttoi sinua?

9. Mita ajattelet tamankertaisesta synnytyksestasi, tunnetasolla? Enta aiemmista synnytyksistasi?

10. Jos voisit muuttaa jotakin tamankertaisessa tai aiemmissa synnytyskokemuksissasi, mita se olisi?

11. Olisiko kukaan tai mikaan kenties auttanut sinua enemman ja paremmin lapi synnytyskokemuksesi?

12. Onko sinulla mielessasi jotakin muuta jonka tahtoisit kertoa synnytyskokemuksistasi?

(Torma, S., 1995)

Part 2

I am interested in learning about your previous birth experience/s.

1. Tell me about particular meanings or practices of caring provided by your support person that were helpful to you.

2. Describe in what ways were these helpful to you.

3. Tell me about particular meanings or practices of caring provided by the nurse that were helpful to you.

4. Describe in what ways were these helpful to you.

I am interested in learning about your present birth experience.

5. Share with me any particular meanings or practices of caring provided by your support person that were helpful to you this time.

6. Describe in what ways were these helpful to you.

7. Share with me any particular meanings or practices of caring provided by the nurse that were helpful to you this time.

8. Describe in what ways were these helpful to you.

(Lamp, J., 1997)

Kysymyksia Odottaville Aideille

Olen kiinnostunut aiemmista synnytyskokemuksistasi.

1. Kerro tuesta/avusta jota tukihenkilosi (aviomies, ystava, ym.) antoi; sanoista ja teoista jotka auttoivat sinua lapi synnytyskokemuksesi.

2. Selvita miten/miksi juuri tama auttoi sinua?

3. Kerro tuesta/avusta jota sairaanhoitajasi antoi? Mita han teki jonka koit helpottavan synnytyskokemustasi?

4. Selvita miten/miksi juuri tama auttoi sinua?

Mieti nyt synnytyskokemustasi jossa mina olin mukana.

5. Millaista tukea/apua tukihenkilosi antoi talla kertaa jonka koit hyodylliseksi ja helpottavaksi?

6. Miten ja miksi juuri tama auttoi sinua?

7. Kerro millaisia hoitomuotoja- tuesta ja avusta jota sairaanhoitajasi antoi, jonka koit helpottavan synnytyskokemustasi?

8. Miten ja miksi juuri tama auttoi sinua?

(Torma, S., 1995)

Appendix D

Observation Enabler for Women in Birth

Context: (describe time, place, environment for labor and/or birth)

_____

_____

Professional Care Generic Care

Names:

_____

_____

The researcher will focus on generic and professional care practices during the following stages of labor allowing for latitude in any unexpected phenomena. The observations may include but not be limited to all verbal and nonverbal actions or measures provided to the woman to facilitate the birth process and/or provide physical and/or emotional comfort.

Care Practices

Stage 1

Stage 2

Stage 3

Stage 4

(Lamp, J., 1997)

Appendix E

Inquiry Guide for Ethnodemographic Information

Date _____ Time _____ Place _____

Name _____

1. I am interested in knowing more about you. Tell me about when and where you were born. Describe your community. Describe for me your family, your childhood.

2. I would like to know more about your present family. Tell me about your children. When and where were they born? Tell me about their father.

3. I would like to know more about your past pregnancies and birth experiences. Tell me about them, describe your labor and birth experiences and the care that you received.

4. I would like to know more about this pregnancy and birth experience. Tell me about your prenatal care, any formal or informal kinds of educational preparation for birth, any decisions planned regarding choices about:

birth site:

care-provider:

<u>labor-stage 1:</u>
-attendees
-apparel
-shave
-enema
-intravenous therapy
-electronic fetal monitor
-focal point
-activity
-food
-analgesia/anesthesia

<u>labor-stage 2:</u>
-setting
-position
-attendees
-lights
-anesthesia
-episiotomy

-intervention/s

labor-stage 3:
-infant care
-mother care

labor-stage 4:
-infant feeding
-infant care
-mother care

(Lamp, J., 1997)

Kysymyksia

Paivays_____ Aika_____ Paikka_____

Nimi_____

1. Tahtoisin tietaa sinusta lisaa. Kerro missa ja milloin olet syntynyt. Kerro yhteisosta jossa asuit. Kerro perheestasi ja lapsuudestasi.

2. Enta nykyinen perheesi? Kerro lapsistasi. Milloin ja missa he ovat syntyneet. Kerro heidan isastaan.

3. Kerro aiemmista raskauksistasi ja synnytyskokemuksistasi ja millaista hoitoa ja huolenpitoa sait osaksesi niiden aikana.

4. Kerro nyt lisaa tamankertaisesta raskaudestasi ja synnytyksestasi. Kerro neuvolastasi, mahdollisista valmennustunneista joihin osallistuit ennen synnytysta, ja mahdollisista paatoksista koskien:

Synnytyspaikkaa:

Synnytyksestasi vastaavaa henkiloa:

Synnytysta:

Vaihe 1.
- osanottajat
- vaatteet
- karvan ajelu
- peraruiske
- tiputus
- puuha
- kipulaakitys

Vaihe 2.
- paikka
- asento
- osanottajat
- valaistus
- kipulaakitys
- mahdollinen leikkaus
- instrumentit

Vaihe 3.
-vastasyntyneen hoito
-aidin hoito

Vaihe 4.
- vastasyntyneen syotto
- vastasyntyneen hoito
- aidin hoito

(Torma, S., 1995)

Appendix F

Leininger's Sequenced Phases Of
Observation-Participation-Reflection Enabler

Ethnonursing Observation-Participation-Reflection Phases

Phases	**1**	**2**	**3**	**4**
Description	Primary Observation and Active Listening (no active participation)	Primary Observation (with limited participation)	Primary Participation (with continued observation)	Primary Reflection and Reconfirmation of findings with informants

Note. From Culture care diversity and universality: A theory of nursing (p. 83) by M. Leininger, 1991. New York: National League for Nursing. Reprinted with permission.

Appendix G

Leininger's Stranger to Trusted Friend Enabler Guide

The purpose of this enabler is to facilitate the researcher (or it can be used by a clinician) to move from mainly a distrusted stranger to a trusted friend in order to obtain authentic, credible, and dependable data (or establish) favorable relationships as a clinician. The user assesses him or herself by reflecting on the indicators as he/she moves from stranger to friend.

Indicators of Stranger (largely etic or outsider's views)	**Date Noted**	**Indicators of Trusted Friend** (largely emic or insider's views)	**Date Noted**
Active to protect self and others. They are gate keepers and guard against outside intrusions. Suspicious and questioning.		Less active to protect self. More trusting of researchers (their gate keeping is down or less). Less suspicious and less questioning of researcher.	
Actively watch and are attentive to what researcher does and says. Limited signs of trusting the researcher or stranger.		Less watching the researcher's words and actions. More signs of trusting and accepting a new friend.	
Skeptical about the researcher's motives and work. May question how findings will be used by the researcher or stranger.		Less questioning of researcher's motives, work, and behavior. Signs of working with and helping the researcher as a friend.	
Reluctant to share cultural secrets and views as private knowledge. Protective of local lifeways, values, and beliefs. Dislikes probing by the researcher or stranger.		Willing to share cultural secrets and private world information and experiences. Offers most local views, values, and interpretations spontaneously or without probes.	
Uncomfortable to become friend or to confide in stranger. May come late, be absent, and withdraw at times from researcher.		Signs of being comfortable and enjoying friends and sharing relationship. Gives presence, is on time, and gives evidence of being a genuine friend.	
Tends to offer inaccurate data. Modifies truths to protect self, family, community, and cultural lifeways. Emic values, beliefs, and practices are not shared spontaneously.		Wants research truths to be accurate regarding beliefs, people, values, and lifeways. Explains and interprets emic ideas so researcher has accurate data.	

Note. From Culture care diversity and universality: A theory of nursing (p. 82) by M. Leininger, 1991. New York: National League for Nursing. Reprinted with permission.

Appendix H

Leininger's Phases of Ethnonursing Analysis for Qualitative Data

Fourth Phase
Major Themes, Research findings, Theoretical Formulations, and Recommendations

This is the highest phase of data analysis, synthesis, and interpretation. It requires synthesis of thinking, configuration analysis, interpreting findings, and creative formulation from data of the previous phases. The researcher's task is to abstract and present major themes, research findings, recommendations, and sometimes theoretical formulations.

Third Phase
Pattern and Contextual Analysis

Data are scrutinized to discover saturation ideas and recurrent patterns of similar or different meanings, expressions, structural forms, interpretations, or explanations of data related to the domain of inquiry. Data are also examined to show patterning with respect to meanings-in-context and along with further credibility and confirmation of findings.

Second Phase
Identification and Categorization of Descriptors and Components

Data are coded and classified as related to the domain or inquiry and sometimes the questions under study. Emic or etic descriptors are studied within context and for similarities and differences. Recurrent components are studied for their meanings.

First Phase
Collecting, Describing, and Documenting Raw Data
(Use of Field Journal and Computer)

The researcher collects, describes, records, and begins to analyze data related to the purposes, domain of inquiry, or questions under study. This phase includes: recording interview data from key and general informants; making observations, and having participatory experiences; identifying contextual meanings; making preliminary interpretations; identifying symbols; and recording data related to the phenomenon under study, mainly from an *emic* focus, but attentive to *etic* ideas. Field data from the condensed and full field journal is processed directly into the computer and coded.
Note. From Culture care diversity and universality: A theory of nursing (p. 95) by M. Leininger, 1991. New York: National League for Nursing. Reprinted with permission.

Appendix I

Coding Data System for the
Leininger, Templin, Thompson Field Research Ethnoscript

Final Code: Effective April 2, 1988

CATEGORIES AND DOMAINS OF INFORMATION

(Includes observations, interviews, interpretations, material and non-material data)

CODE NUMBERS

CATEGORY I: GENERAL CULTURAL DOMAINS OF INQUIRY

1. World View
2. Cultural-social lifeways and activities (typical day/night)
3. Ethnohistorical (includes chrono-data, acculturation, cultural contacts, etc.)
4. Environmental contexts (i.e., physical, ecological, cultural, social)
5. Linguistic terms and meanings
6. Cultural foods related to care, health, illness, and environment
7. Material and non-material culture (includes symbols and meanings)
8. Ethnodemographies (numerical facts, dates, population size and other numerical data)
9.

CATEGORY II: DOMAIN OF CULTURAL AND SOCIAL STRUCTURAL DATA

(Includes normative values, patterns, functions and conflicts)

10. Cultural values, beliefs and norms
11. Economic factors
12. Educational factors
13. Kinship (family ties, social network, social relationships, etc.)
14. Political and legal factors
15. Religious, philosophical and ethical values and beliefs
16. Technological factors
17. Interpersonal relationships (individual groups or institutions)
18.
19.

CATEGORY III: CARE, CURE, HEALTH (WELL-BEING) AND ILLNESS OF FOLK AND PROFESSIONAL LIFEWAYS

20. Folk (includes popular health and illness beliefs, values and practices)
21. Professional health and illness beliefs, values and practices
22. Human care/caring and nursing (general beliefs, values and practices)
23. Folk care/caring (*emic* or indigenous beliefs, values and lifeways)
24. Professional care/caring (*etic* beliefs, values and lifeways)
25. Professional nursing care/caring (*etic* and *emic*) lifeways (congruence and conflict areas)

26. Non-care/caring beliefs, values, and practices
27. Human cure/curing (general ideas, beliefs, values and practices)
28. Folk cure/curing (*emic* beliefs and practices)
29. Professional cure/curing (*emic* and *etic* perspectives)
30. Alternative (new) or emerging care/cure systems
31.
32.
33.
34.

CATEGORY IV: HEALTH AND SOCIAL SERVICE INSTITUTIONS
(Administrative norms, beliefs and practices with meanings in-contexts)
35. Cultural-social norms, beliefs, values and context
36. Political-legal aspects
37. Economic aspects
38. Technological factors
39. Environmental factors
40. Educational factors (formal and informal)
41. Social organization or structural features
42. Decisions and action patterns
43. Interdisciplinary norms, values and collaborative practices with medicine, social work, nursing, auxiliary staff, etc.
44. Nursing specialties and features
45. Non-nursing specialties and features
46. Ethical/moral aspects
47.
48.
49.

CATEGORY V: LIFE CYCLE AND INTERGENERATIONAL PATTERNS
(Includes Ceremonies and Rituals)
50. Life cycle male and female socialization and enculturation
51. Infancy and early childhood
52. Adolescence or transitions to adulthood
53. Middlescence
54. Advanced years
55. Cultural life cycle values, beliefs and practices
56. Cultural life cycle conflict areas (i.e., intergenerational)
57. Special subcultures
58. Life passages (i.e., birth, marriage, death, etc.)
59.
60.

CATEGORY VI: METHODOLOGICAL AND OTHER RESEARCH FEATURES OF THE STUDY
61. Specific methods or techniques used
62. Key informants

63. General informants
64. Enabling tools or instruments used
65. Problem areas, concerns or conflicts
66. Strengths, favorable and unanticipated outcomes of researcher or informants (i.e., subjective data and questions)
67. Unusual incidents, interpretations and questions, etc.
68. Factors facilitating or hindering the study (i.e., time, staff, money, etc.)
69. Emic data
70. Etic data
71. Dialogue by interviewer
72. Dialogue by someone other than informant or interviewer
73. Additional contextual data (including non-verbal symbols, total view, environmental features, etc.)
74. Informed consent factors

Note. From Leininger-Templin-Thompson ethnoscript qualitative software program: Users handbook. By M. Leininger, T. Templin, and T. Thompson (1991). Detroit: Wayne State University. Reprinted with permission.

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ABSTRACT

GENERIC AND PROFESSIONAL CARE MEANINGS AND PRACTICES OF FINNISH WOMEN IN BIRTH WITHIN LEININGER'S THEORY OF CULTURE CARE

by

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December 1998

Adviser: Dr. Madeleine Leininger

Major: Nursing

Degree: Doctor of Philosophy

The domain of inquiry was generic and professional cultural care meanings and practices of Finnish women in birth. The purpose was to discover culture care diversities and universalities of generic and professional care of Finnish women in birth. Discovery of the epistemic and ontological dimensions of women's health and well being related to providing culture care was held to contribute to the body of transcultural nursing knowledge. Previous transcultural nursing studies of birthing in different cultures with a care focus was held as essential to understand health care practices and well being. The need exists for further indepth studies of care meanings and practices for women of diverse cultures and will significantly encourage holistic and humanistic care.

Leininger's theory of Culture Care with the ethnonursing and audiovisual research methods, was used to study the generic and professional care meanings and practices. Several enablers were used to obtain indepth

knowledge about Finnish birthing practices from the holistic emic and etic perspectives. The data were obtained by using observation and reflection in the active participation in the birth experiences of ten Finnish women identified as key informants. In the analysis of data, Leininger's Phases of Ethnonursing Analysis for Qualitative Data was used for a systematic and indepth ethnonursing investigation. Major themes identified in the generic care practices were found to be comfort care and physical care; themes identified in the professional care practices were found to be ritualized care and anticipatory care. Although many universalities were found to exist in the generic and professional care meanings and practices, the diversity that was identified existed in the satisfaction expressed with the birth experience. This indepth knowledge of the generic and professional care meanings and practices, the cultural care dimensions of the Finnish culture, and the cultural diversities and universalities that exist in the findings will assist nurses in planning and providing culturally congruent care--important implications as our world becomes more culturally diverse.

AUTOBIOGRAPHICAL STATEMENT

Judith Kilmer Lamp earned her Bachelor of Science Degree in Nursing from Ohio State University, Columbus, Ohio in 1974. Upon graduation she became employed as a staff nurse in labor and delivery at Riverside Methodist Hospitals in Columbus, Ohio and began her teaching career as a clinical instructor for the Riverside Methodist Hospital School of Nursing.

Upon completion of her Masters Degree in 1979 from Ohio State University College of Nursing, Judith taught Nursing of Childbearing Families at the Medical College of Ohio in Toledo, Ohio. Her doctoral study at Wayne State University College of Nursing began in 1991 with a focus on transcultural nursing and a minor in anthropology. In 1994 she conducted an ethnonursing study at the Toledo Hospital Center for Women and Children on the care of Euro-American women in birth. During the summer of 1995, she collected data at the Central Women's Hospital of the University of Helsinki in Helsinki, Finland for her doctoral research.

Judith was awarded the Leininger Transcultural Nursing Research Award from the Transcultural Nursing Society and the Sigma Theta Tau International Research Award from Zeta Theta Chapter in 1996 to support her doctoral research on women in birth. She was selected as the 1997 recipient of the Leininger Transcultural Nursing Award at Wayne State University. Currently, she is an Associate Professor at the Medical College of Ohio in Toledo, Ohio teaching courses on Women's Health and Transcultural Nursing as an elective course in both undergraduate and graduate programs.